THE
MEDICAL AND SURGICAL
REPORTER.

No. 1986. MARCH 30, 1895. Vol. LXXII—No. 13

## ORIGINAL ARTICLES.

### INJURIES OF THE VERTEBRAL COLUMN AND SPINAL CORD AND THEIR TREATMENT.*

J. C. BIDDLE, M.D., Fountain Spring, Pa.

In the selection of my subject for this paper I do so because I am led to believe that the injuries to the bony structure of the vertebral column and the spinal cord have not received the attention at the hands of the surgeon that their importance demands. The brain, uterus, ovaries and, now that important organ, the appendix, each have received respectful attention, since the introduction of the aseptic or antiseptic treatment of wounds. The inordinate impetus, the brilliant successes achieved in operative surgery during the last few years must place the treatment of injuries of the vertebral column and spinal cord upon an entirely new basis.

The operation of laminectomy for an injury to the vertebral column was first performed by a young surgeon named Henry Kline, at St. Thomas Hospital, London, June 16, 1814, at the suggestion of Sir Astley Cooper. The patient died three days after the operation and the surgeon believed he had hastened the fatal termination by the operation. The operation is still held by many surgeons to do positive injury, because of the difficulties which attend its performance. The operation has been performed, however, many times, and by the most eminent surgeons of Europe and America. They have, however, met with little success.

My experience has taught me that operations on the vertebral column are attended with as good results as those upon the brain or abdomen when you take into consideration the nature of the surroundings. We remove portions of the alimentary canal and large areas of brain substance without any apparent inconvenience or discomfort to the patient. Where is there a record of a case with total destruction of a part of the spinal cord and complete recovery has taken place? It is therefore manifest that the cord, as a whole, is of more importance, and is more intricate than either brain or alimentary canal and we should not expect the same percentage of recoveries, or say that the operation of laminectomy has not its utility in a certain number of cases. It is my opinion that in all cases of dislocation with extreme displacement of the vertebral column, or in fracture dislocations where the cord has been crushed or lacerated, the injury is irreparable. This is to say that the spinal cord is incapable of regaining or of repairing any extensive

* A paper read before the Lehigh Valley Medical Association, at Easton, January 31, 1895. From advance sheets of the "Lehigh Valley Medical Magazine."

lesion. But how can you determine which cases will and which cases will not recover? I am clearly of the opinion that the only way to answer the question immediately is to make an exploratory incision in the cases where paraplegia exists. The vertebral column is so thickly covered by muscles, especially in the lower dorsal and lumbar region, that it is generally impossible to detect the usual symptoms which we find in fractures of the long bones—crepitation and preternatural mobility. Deformity or displacement may exist without making sufficient pressure to produce paralysis because of the large caliber of the vertebral canal. Again we should not attempt to elicit these signs for fear of adding to the existing injury. By making an incision and approaching the parts carefully no harm can occur. Just in the same manner as we would make an irreducible simple fracture of the long bones a compound one and be able to adjust the deformity accurately.

This procedure has several advantages. By the exploratory incision you are certain as to the amount of injury. The spines of the vertebra should be removed near the seat of the injury thereby preventing pressure upon the bed and producing exhausting bed-sores. Again, you give the extravasated blood the opportunity of escaping and, in this way, prevent a possible abscess which would be certain to take the life of the patient. The only objection to this, which would be, by some surgeons, considered a radical and unwarranted procedure, is the shock attending the etherization and operation. Out of fourteen cases operated upon by myself since September, 1890, for fracture or dislocation with total paraplegia, shock has not added to the number of deaths or hastened the otherwise fatal termination. I am firmly convinced that the chances for recovery are diminished in waiting for nature to effect a cure. When there is bone pressure, why not remove it at once? In injuries below the first lumbar vertebra to the cauda equina I would be inclined to wait until after the acute symptoms had passed away, say a week or ten days, and then, if no improvement was manifest, I would operate. Even here why trust too long to the capacity for regeneration when there is great and constant danger of total destruction by the slightest movement of the body? Here, if the nerve be completely separated by the injury and bone or ligaments be interposing they can be removed and the nerve brought together by suture if necessary. We all know that complete division and separation of nerve is no barrier to its recovery but it must have an opportunity to unite and it is plainly our duty to put it in a proper position for nature to establish the reunion.

From my position then I will not sum up or conclude, as has been done in the past by all authors and surgeons, that "the operation of laminectomy for traumatic lesions, as compared with the condition which it is intended to relieve, should be abandoned because *a priori* argument and the results of published cases show that it is unlikely to be of service." I take it that this conclusion is absolutely wrong. It is true that the recoveries recorded by such surgeons as Erichsen, Hutchison, Leyden, Bryant, Macewen, Thorburn, Abbe, and others, are not such as would enthuse or inspire confidence in a conservative and conscientious surgeon. It is a wonder that the operation has not inspired some one who desires to cut and saw for a living or one who was trying to make a record for himself like the fast disappearing ovary fiend and now the appendix surgeon who can smell the cause of an appendicular colic (?).

The diagnosis then in my manner of procedure is not a matter of inference. You will know that the paralysis is due either to bone-pressure, an intra-thecal hemorrhage or perhaps an extensive laceration, crushing or causing a total separation of the cord. If you were convinced beyond a reasonable doubt from the symptoms, that the paralysis was due to a clot you would not be justified in operating. From the cause then you must deduct, in a great measure, your conclusion for surgical interference in cases which are suffering with paraplegia.

The symptoms of dislocation with extreme displacement and those of fracture of the vertebral column with injury to the cord are so manifest that I need scarcely take your time in describing them.

In the time of my service at the hospital 110 cases of severe injuries to the vertebral column have come under my notice and were divided as follows:

| | |
|---|---|
| Fracture dislocations | 12 |
| Fractures | 44 |
| Dislocations | 23 |
| Partial dislocations | 31 |

On the 12 fracture dislocations, 9 or 75 per cent. died, 2 were improved, and one unimproved. These were treated 966 days.

Of the 44 fractures, 25 or $56\frac{9}{11}$ per cent. died, 10 recovered, 5 were improved, and 4 were unimproved. These were treated 4,580 days.

Of the 23 dislocations, 6 or $26\frac{3}{23}$ per cent. died, 7 recovered, 8 were improved, and 2 were unimproved. These were treated 3,810 days.

Of the 31 partial dislocations, 1 or $3\frac{1}{31}$ per cent. died, 16 recovered, 12 improved, and 2 were unimproved. These were treated 3,909.

The medical treatment in these cases consists in keeping the patient at complete rest, with the upper portion of the body elevated, especially if the injury be in the cervical or dorsal region. The bowels should only be moved when positively necessary, and then only by enemas; brisk cathartics should seldom be given. A soft catheter should be used about every four hours so as to keep the bladder empty. Great care should be taken so as not to infect the bladder. When cystitis occurs, the bladder should be carefully washed out twice a day with a saturated solution of boracic acid and then again with a solution of ten grains to the ounce, or a one to sixty solution of creolin. Quinine in five-grain doses four times a day until the physiologic effects are complained of; stimulants, tri-nitrin and digitalis with brandy are given until shock disappears; this may last from two to even five days. Morphine and paraldehyde should be administered hypodermatically to allay pain, and after the shock has disappeared, thirty grains of chloralamid, or twenty grains of potassium bromid and five grains of chloral hydrate should be given frequently enough to procure sleep. The patient should be kept perfectly dry and clean and his back dusted with europhen aristol. The patient should not be turned upon his side during the first four or five weeks. He should be raised when necessary by two attendants, one at his shoulders the other at his legs and lift him by pulling in opposite directions; if the patient be very heavy they can be assisted by two in the middle.

Of the fourteen severe cases operated upon since September 8, 1890, ten had the spinal cord completely or partially severed or crushed, and death was inevitable. In the remaining four the cord was compressed. Of these latter four, two have recovered so as to be able to perform manual labor, one following the avocation of that of a huckster, the other a nurse. The remaining two are still under treatment and much improved.

To illustrate our subject let me present to you a brief synopsis of three of the cases coming under my personal treatment.

In case 49* (the first recovery) there was a partial dislocation of the ninth dorsal vertebra. There was complete motor and sensory paralysis of the legs below the knees, but some slight motion and sensation of the muscles of the thighs remained. There was complete paralysis of the bladder and rectum, and extensive bed-sores at the point of fracture and on the sacrum. The patient was very much exhausted from pain, sleeplessness and cystitis, as he had sustained the injury three months before his admission. The urine was purulent and fetid. The patient was prepared for the operation and an incision was made extending from the seventh to the eleventh dorsal spine. The spinous processes of the eighth, ninth, tenth and eleventh vertebræ were removed and the laminæ of the eighth, ninth and tenth. The cord was found to be compressed between the ninth and tenth dorsal vertebræ. The pressure was removed by cutting the bone away. The sharp edge anterior to the cord due to the luxation was cut away and the cord thus freely liberated; the wound was closed in the usual manner and healed kindly. The bed-sores, too, soon disappeared and the patient made a good recovery, being in the hospital one hundred and eight (108) days from the time of the operation.

In case No. 56† the symptoms were about the same with the addition of profound shock, he being admitted a few hours after the injury. Upon making an exploratory incision a short time after his reception, the cord was found to be completely separated between the ninth and tenth dorsal vertebræ. He survived but ten days.

---

* See Appendix.

† See Appendix.

In case No. 67†, that of Thomas M., aged nineteen years, admitted May 8, 1891, it was found, after an exploratory incision, that he had sustained a fracture of the eleventh dorsal vertebra by being struck with the sharp corner of the oil-box of a car. The laminæ were found to be driven in making compression upon the cord. The laminæ of the tenth, eleventh and twelfth vertebræ, with the spines of the ninth, tenth, eleventh and twelfth were removed and the symptoms of paralysis, which had existed, soon began to improve and, at the end of 231 days after the operation, he had sufficiently recovered to walk without the aid of crutches and, with the exception of some slight paralysis of the posterior muscles of the thighs, made a good recovery.

And now let me say in conclusion, that here undoubtedly remains an extensive field for thought and experiment. Much has been written upon the subject by both physiologists and surgeons; but of what value are theories, if, after all, we cannot show, by a successful practice, that our theory has been more than a vague suspicion or a mere notion. If anything does inspire confidence in a surgeon for successful work, surely it must be that incentive arising, not out of a mere belief, but rather out of that experience in which belief has been transformed by observation and experiment into positive knowledge. I believe the subject I present to you today to be a most vital one. We all know the delicate and peculiar construction, not to say exclusive nature of the spinal cord, and the delicacy of operations connected therewith; and yet the rapid strides made in surgery during the last ten years teaches us that all knowledge is not yet gained in our science any more than that of other professions. In fact our eyes have been opened to such an extent that we often feel like using the words of the immortal Shakespeare—

"There are more things in heaven and earth, Horatio,
Than are dreamt of in our philosophy."

Undoubtedly right here is opened up a wide field for the inquisitive mind. I do not hesitate in saying that, were it not for the conservative position I previously held in regard to laminectomy, and the adverse conclusions of our best surgeons, out of one hundred and ten (110) cases, with forty-one (41) deaths, that have come before me during the last eleven years, more lives might have been saved.

†See Appendix.

## APPENDIXES.

### I.

### DETAILS OF THE 110 CASES.

Case 1.—J. R., admitted to the hospital, December 10, 1883, fracture dislocation of 11th dorsal, died 2 months after being discharged, in hospital 298 days.

Case 2.—V. K., admitted January 9, 1884, fracture dislocation of 10th dorsal, died 4 months after being discharged, in hospital 118 days.

Case 3.—J. W., admitted January 10, 1884, fracture dislocation of 12th dorsal, died 3 days after admission.

Case 4.—J. W., admitted March 10, 1884, partial dislocation of 10th dorsal, in hospital 202 days.

Case 5.—J. S., admitted May 15, 1884, ancient partial dislocation of 10th dorsal, (3 years ago,) not benefitted, in hospital 31 days.

Case 6.—J. O., admitted June 30, 1884, partial dislocation of either 10th or 11th dorsal, in hospital 100 days.

Case 7.—A. H., admitted July 31, 1884, partial dislocation of 11th dorsal, improved, now a chronic invalid, in hospital 32 days.

Case 8.—E. F., admitted August 2, 1884, fracture dislocation of 10th dorsal, died 31 days after admission.

Case 9.—P. M., admitted September 17, 1884, dislocation of either 7th or 8th dorsal, in hospital 145 days.

Case 10.—P. C., admitted October 20, 1884, partial dislocation of 10th dorsal, in hospital 118 days.

Case 11.—M. O., admitted June 4, 1885, fracture of 11th dorsal, died 202 days after admission.

Case 12.—W. C., admitted October 10, 1885, fracture dislocation of either 10th or 11th dorsal, died 12 days after admission.

Case 13.—J. K., admitted December 5, 1885, fracture of 1st lumbar, in hospital 158 days,

Case 14.—G. B., admitted February 20, 1886, fracture dislocation of 11th dorsal, died in 2 weeks after leaving the hospital, in hospital 368 days.

Case 15.—J. M., admitted March 18, 1886, dislocation of either 11th or 12th dorsal, in the hospital 410 days.

Case 16.—E. A., admitted April 19, 1886, dislocation of either 9th or 10th dorsal, unimproved, in hospital 316 days.

Case 17.—J. N., admitted April 19, 1886, partial dislocation of 7th dorsal, in hospital 37 days.

Case 18.—D. S., admitted July 1, 1886, partial dislocation of 11th dorsal, chronic invalid, in hospital 37 days.

Case 19.—J. E., admitted July 26, 1886, dislocation of either 8th or 9th dorsal, slightly improved, in hospital 232 days.

Case 20.—T. C., admitted September 7, 1886, fracture dislocation of 11th dorsal, died 28 days after admission.

Case 21.—R. F., admitted September 7, 1886, partial dislocation, died about 6 months after leaving the hospital, in hospital 136 days.

Case 22.—J. B., admitted October 1, 1886, partial dislocation of 6th or 7th dorsal, in hospital 317 days.

Case 23.—J. C., admitted November 10, 1886, partial dislocation of either 7th or 8th dorsal, in hospital 145 days.

Case 24.—J. R., admitted November 13, 1886, partial dislocation of 1st lumbar, in hospital 90 days.

Case 25.—J. K., admitted December 14, 1886, partial dislocation of either 2nd or 3rd lumbar, in hospital 127 days.

Case 26.—F. F., admitted March 10, 1887, fracture dislocation of 1st lumbar, in hospital 110 days.

Case 27.—E. T., admitted August 25, 1887, fracture dislocation of 10th dorsal, in hospital 135 days.

Case 28.—A. S., admitted October 13, 1887, partial dislocation of 11th dorsal, died 205 days after admission.

Case 29.—M. B., admitted October 18, 1887, fracture of 11th dorsal, in hospital 140 days.

Case 30.—M. M., admitted February 15, 1888, fracture of 10th dorsal, died 1 day after admission.

Case 31.—M. M., admitted October 3, 1887, partial dislocation of either 6th or 7th dorsal, partial paraplegia remaining, in hospital 317 days.

Case 32.—O. G., admitted February 21, 1878, partial dislocation 10th dorsal, unimproved, removed by his friends in 6 days.

Case 33.—J. P., admitted March 3rd, 1888, fracture of 1st lumbar, died 146 days after admission.

Case 34.—N. S., admitted April 4th, 1888, fracture of 1st lumbar, died 71 days after admission.

Case 35.—J. M., admitted May 18, 1888, partial dislocation of 10th dorsal, in hospital 13 days.

Case 36.—P. F., admitted June 26, 1888, fracture of either 9th or 10th dorsal, died 11 days after admission.

Case 37.—A. F., admitted June 26, 1888, fracture of 3rd dorsal, died on day of admission.

Case 38.—A. E., admitted August 1, 1888, fracture of 1st lumbar, died 71 days after admission.

Case 39.—F. S., admitted August 5, 1888, fracture of 10th or 11th dorsal, died 24 days after admission.

Case 40.—J. M., admitted August 23, 1888, partial dislocation of 2nd lumbar, in hospital 76 days.

Case 41.—J. S., admitted October 16, 1888, fracture of 10th dorsal, died 3 days after admission.

Case 42.—F. D., admitted October 27, 1888, fracture of 1st lumbar, died 10 days after admission.

Case 43.—J. M., admitted January 20, 1889, fracture of 3rd cervical, died 1 day after admission.

Case 44.—J. M., admitted March 14, 1889, partial dislocation of 7th dorsal, improved, in hospital 35 days.

Case 45.—J. A., admitted March 21, 1889, fracture of 10th dorsal, died on day of admission.

Case 46.—P. G., admitted March 29, 1889, fracture dislocation of either 11th or 12th dorsal, died 2 days after admission.

Case 47.—T. K., admitted May 12, 1889, fracture of 10th dorsal, died 120 days after admission.

Case 48.—J. G., admitted May 12, 1889, dislocation of either 2nd or 3rd lumbar, in hospital 293 days.

Case 49.—E. E., admitted June 17, 1889, partial dislocation of 9th dorsal, in hospital 189 days.

Case 50.—N. P., admitted July 2, 1889, fracture of either 4th or 5th lumbar, in hospital 138 days.

Case 51.—G. W., admitted August 2, 1889, fracture of 11th dorsal, died 38 days after admission.

Case 52.—T. J. admitted November 25, 1889, partial dislocation of 1st lumbar, in hospital 84 days.

Case 53.—R. J., admitted November 28, 1889, dislocation of either 8th or 9th dorsal, in hospital 138 days.

Case 54.—S. K., admitted December 5, 1889, fracture of 1st or 2nd lumbar, in hospital 147 days.

Case 55.—F. S., admitted December 20, 1889, fracture of 9th dorsal, died 16 days after admission.

Case 56.—B. H., admitted January 31, 1890, fracture of 9th dorsal, died 10 days after admission.

Case 57.—J. B., admitted April 25, 1890, fracture of 9th dorsal, died on day of admission.

Case 58.—A. M., admitted May 10, 1890, dislocation of 11th dorsal, improved, in hospital 225 days.

Case 59.—F. M., admitted June 14, 1890, fracture of 10th dorsal, improved, in hospital 301 days.

Case 60.—S. W., admitted July 21, 1890, partial dislocation of 11th and 12th dorsal, in hospital 31 days.

Case 61.—A. A., admitted March 6, 1891, fracture of 3rd and 4th lumbar, died on day of admission.

Case 62.—J. M., admitted March 10, 1891, fracture dislocation of 2nd lumbar, died in 592 days after admission.

Case 63.—M. G., admitted March 19, 1891, partial dislocation of 11th and 12th dorsal, improved, in hospital 109 days.

Case 64.—W. H., admitted March 28, 1891, fracture of 3rd and 4th dorsal, unimproved, in hospital 85 days.

Case 65.—W. L., admitted April 13, 1891, fracture dislocation of 11th dorsal, died 111 days after admission.

Case 66.—P. D., admitted April 29, 1891, fracture of 9th dorsal, died 10 days after admission.

Case 67.—T. M., admitted May 8, 1891, fracture of 11th dorsal, total paraplegia except slight motion and sensation of posterior muscles of thighs, in hospital 231 days.

Case 68.—A. B., admitted June 23, 1891, partial dislocation of either 2nd or 3rd lumbar, slight paralysis, in hospital 33 days.

Case 69.—M. B., admitted June 23, 1891, fracture of 8th dorsal, slight paralysis remaining, in hospital 47 days.

Case 70.—J. C., admitted June 29, 1891, comminuted fracture dislocation of 1st lumbar, cord almost separated, died 35 days after admission.

Case 71.—A. G., admitted August 5, 1891, partial dislocation of 11th dorsal, improved, in hospital 95 days.

Case 72.—J. B., admitted August 11, 1891, fracture of 10th and 11th dorsal, died on day of admission.

Case 73.—M. H., admitted November 19, 1891, partial dislocation of 2nd lumbar, in hospital 322 days, improved.

Case 74.—C. K., admitted November 30, 1891, dislocation of 12th dorsal, died 565 days after admission.

Case 75.—J. M., admitted December 3, 1891, dislocation of 11th dorsal, died 87 days after admission.

Case 76.—J. G., admitted April 21, 1890, partial dislocation of 5th dorsal, in hospital 24 days.

Case 77.—A. C., admitted May 8, 1890, fracture of 10th dorsal, died 4 days after admission.

Case 78.—J. A.. admitted June 30, 1890, partial dislocation of either 2nd or 3rd lumbar, in hospital 11 days.

Case 79.—S. S., admitted March 3, 1892, partial dislocation of 12th dorsal, improved, in hospital 92 days.

Case 80.—A. A., admitted April 7, 1892, dislocation of 10th dorsal, died 3 days after admission.

Case 81.—J. L., admitted May 6, 1892, partial dislocation of either 1st, 2nd, or 3rd lumbar, improved, in hospital 23 days.

Case 82.—J. C., admitted June 20th 1892, partial dislocation of either 4th or 5th dorsal ancient, improved, in hospital 26 days.

Case 83.—C. B., admitted June 22, 1892, fracture of 8th dorsal, died 4 days after admission.

Case 84.—J. L., admitted August 10, 1892, dislocation of 10th, 11th, and 12th dorsal, died 24 days after admission.

Case 85.—J. S., admitted October 18, 1892, dislocation of 10th and 11th lumbar, in hospital 180 days.

Case 86.—B. S., admitted October 27, 1892, fracture of 12th dorsal, improving, remaining in hospital.

Case 87.—F. W., admitted November 7, 1892, fracture dislocation of 10th dorsal, died 5 days after admission.

Case 88.—W. R., admitted December 12, 1892, dislocation of 10th dorsal, improved, in hospital 320 days.

Case 89.—G. R., admitted February 8, 1893, fracture of 9th dorsal, died 77 days after admission.

Case 90.—J. B., admitted April 1, 1893, dislocation of 9th, 10th, and 11th dorsal, improved, in hospital 65 days.

Case 91.—C A., admitted April 18, 1893, dislocation of last dorsal and 1st and 2nd lumbar, improved, in hospital 421 days.

Case 92.—J. M., admitted August 12, 1893, fracture dislocation of 10th dorsal, died 19 days after admission.

Case 93.—J. Z., admitted August 13, 1893, partial dislocation of 9th dorsal, cord was compressed, in hospital 19 days.

Case 94.—J. C., admitted October 9, 1893, fracture of 12th dorsal, improved, in hospital 61 days.

Case 95.—A. G., admitted October 12, 1893, fracture of 1st lumbar, improved, in hospital 235 days.

Case 96.—J. H., admitted October 29, 1893, dislocation of 3rd lumbar, improved, remaining in hospital.

Case 97. —J. B., admitted November 13, 1893, partial dislocation of 9th dorsal, in hospital 93 days.

Case 98.—A. M., admitted November 23, 1893, fracture dislocation of 1st lumbar, died 33 days after admission.

Case 99.—G. Z., admitted January 12, 1894, fracture of 12th dorsal, in hospital 314 days.

Case 100.—J. F., admitted March 1, 1894, fracture dislocation of 2nd lumbar, remaining in hospital, able to walk with crutches, improving.

Case 101.—J. B., admitted April 11, 1894, fracture of 3rd lumbar, in hospital 119 days.

Case 102.—C. S., admitted June 12, 1894, partial dislocation of 4th dorsal, in hospital 6 days, removed to his home.

Case 103.—P. G., admitted June 27, 1894, partial fracture of 12th dorsal, in hospital 42 days.

Case 104.—H. A., admitted June 30th, 1894, fracture of the arches of the 11th and 12th dorsal, and the spinous processes of the 1st and 2nd lumbar, total paralysis below the knees, remaining in the hospital.

Case 105.—J. F., admitted September 21, 1894, fracture of 9th dorsal, died on day of admission.

Case 106.—E. B., admitted October 5, 1894, partial dislocation of 10th dorsal, remaining in hospital.

Case 107.—D. L., admitted October 26, 1894, partial dislocation of 5th dorsal, remaining in hospital.

Case 108.—J. C., admitted November 22, 1894, fracture dislocation of 10th dorsal, died 7 days after admission.

Case 109.—J. C., admitted December 12th, 1894, partial dislocation of 5th dorsal, remaining in hospital.

Case 110.—A. N., admitted January 8, 1895, fracture dislocation of 11th dorsal, died on day of admission.

## II.

## SYNOPSIS OF CASES OPERATED UPON.

| Symptoms Before the Operation. | Nature of the Operation and Extent of the Injury to the Cord and Vertebral Column, and Results. |
|---|---|
| No. 1. Operated on Sept. 8, 1890. Thomas K., aged 35, a miner by occupation, injured Jan. 25, 1890. Had a fracture of the left thigh and a fracture of the 5th, 6th, 7th, 8th, 9th and 10th ribs. I saw the patient in consultation a few hours after the accident. Was in profound shock. Face dejected and showing extreme anxiety. He came to the hospital 3 months after the injury was received. Thigh and ribs united. There was complete paraplegia from just below the umbilicus in front and from the nates behind. There were extensive bed-sores both in the lumbar region and at the point of injury. He had cystitis and orchitis. Very much emaciated. Respiration frequent and shallow. He had some hypostatic pneumonia. | An incision was made extending from the 8th to the 12th dorsal. Very little hemorrhage. Ether was used as an anesthetic. The spines of 9th, 10th, 11th and 12th, with the arches of the 10th and 11th were cut away. A fracture was found with extreme displacement of the vertebral column. The cord was completely severed. Its cut ends being two and one-half inches apart. Wound healed.<br>Died 3 weeks after the operation. |
| No. 2. Operated on Sept. 8, 1890. Evan E., aged 21, mine laborer by occupation. Complete motor and sensory paralysis below the knees. Some slight motion and sensation of the thighs. Paralysis of the spincters. Bed-sores, cystitis, urine purulent and fetid. Injured 3 months before his admission. | An incision was made extending from the 7th to the 11th dorsal spine. The spinous process of the 8th, 9th, 10th and 11th, and the laminæ of 8th, 9th and 10th were removed. Cord was compressed. Wound healed kindly and the patient improved rapidly. Torsion and hot water were used to arrest the hemorrhage.<br>Recovery. |
| No. 3. Operated on Dec. 20, 1890. Frank S., aged 20, railroad brakeman by occupation. Complete paraplegia, severe shock, feeble, rapid respiration, high temperature. | Spines of 8th, 9th, 10th and 11th with the laminæ of the 9th and 10th were removed. Fracture of the 9th dorsal. Cord completely separated.<br>Died 16 days after his admission. |
| No. 4. Operated on Jan. 31, 1891. Benjamin I. H., aged 38, miner by occupation. Paraplegia absolute as high as the umbilicus, shock severe, excruciating pain at the point of injury, high temperature, rapid, feeble pulse. | Operation same as in former cases. Comminuted fracture. Cord and membranes completely separated. Pain relieved, I think because the peripheral nerves from above the fracture were liberated.<br>Died 10 days after his admission. |
| No. 5. Operated on Mar. 10, 1891. Joseph M., aged 46, miner by occupation. Compound fracture of frontal bone. Paraplegia, cystitis, incontinence of urine and feces, limbs wasted, improved for a time, so that he could stand with some assistance, chills and fever with spasms of the limbs and emaciation followed. | Operation performed 592 days after his admission. The cauda equina was found to be atrophied and soft. Hard inflammatory tissue filled the vertebral canal.<br>Death on the day of the operation, which was partly expected. |
| No. 6. Operated on May 8, 1891. Thomas M., aged 19, laborer by occupation. Paraplegia; severe pain at 11th dorsal. The spine of the 11th dorsal indented, severe pain and spasms in posterior muscles of the thigh, | The spinous processes of the 9th, 10th, 11th and 12, and the laminæ of the 10th, 11th, and 12th were cut away; they were driven down, making compression upon the cord, especially the 11th. Pain and spasms soon subsided. |

| | | | |
|---|---|---|---|
| cystitis, constipation, had to use the catheter to relieve his bladder. | Sensation and motion gradually returning. Recovery except slight paralysis of posterior muscles of the thighs, with some ankle clonus. Cannot retain his urine long. | No. 12. Operated on Jan., 1894. Brom S., aged 24, mine laborer by occupation. Total paralysis of left leg and part of thigh. Right leg or thigh not so bad. Extreme ankle clonus, lacerated wounds of scalp, incontinence of urine and feces, cystitis. Priapism at times lasting from 6 to 12 hours. Has had violent attacks of orchitis. The extensor muscles are slightly improving. | Operated, 3 months after his admission, because of beginning gangrene of his toes on the left foot. This side being worse, it was evident that the pressure was on some of the nerves in the sacrum. It was found that there was compression on two of the nerves as they emerged from the sacrum. The compression was relieved. The gangrene soon disappeared. His limbs are atrophied, though he can move his legs. Under treatment for 819 days. He is able to walk with crutches. |
| No. 7. Operated on June 29, 1891. James C., aged 18, driver in the mines by occupation. Absolute motor and sensory paralysis from just below the anterior, superior spinous process in front and gluteal notch behind. Excruciating pain in the lumbar region extending into genitalia, slow, feeble pulse, labored respiration, shock continued for 5 days. | Operation the same as preceding cases. Membranes lacerated and cord almost separated. Operation performed 2 weeks after the injury. Pus had formed and was burrowing beneath the muscles and had entered the vertebral canal. Death in 35 days. | | |
| No. 8. Operated on Nov. 30, 1891. Charles K., aged 37, miner by occupation. Paraplegia, symptoms similar to former case. | Lateral dislocation of 12th dorsal, cord crushed so that nothing but the membranes could be felt for nearly an inch. Tension taken off of the cord by cutting away the sides of the arches. Wound healed. Died in 565 days from exhaustion. | No. 13. Operated on March 22, 1893. George R., aged 23, miner by occupation. Total paralysis of lower part of trunk and limbs. Involuntary defecation and micturition. Severe pain, 8th dorsal spine very prominent, difficulty in breathing. severe shock, death imminent, operation delayed, gangrene in lumbar and sacral region, abscess in scrotum. | Some improvement in bed-sore, abscess healed, operation 6 weeks after reception of injury. 9th dorsal vertebra was fractured and driven in tightly compressing the cord. Wound healed and some improvement followed. Patient was taken to his home 5 weeks after the operation. |
| No. 9. Operated on May 8, 1892. Andrew C., aged 32, railroad laborer by occupation. Gun-shot wound of neck. High temperature. Respiration slow and labored. Delirium. Cyanosis of the face, neck and extending down over his chest. | Fracture of 5th or 6th cervical; cord and membranes lacerated. Inflammation of membranes and cord. The spines of the 5th and 6th, and a part of the arches were cut away, as little bone was removed as possible. Post mortem showed hemorrhages into brain and inflammation of the membranes. Died in 4 days. | No. 14. Operated on August 18, 1894. George Z., aged 26, a miner by occupation. On the day of his admission, January 12, 1894, the lower portion of his body and limbs were completely paralyzed. Fracture of forearm, compound fracture of second metacarpal, compound complicated fracture of last phalanx of index finger, with extensive lacerations of hand and face, and contusions of back. He was suffering from severe shock, and it seemed as though death would soon intervene. Pulse weak and rapid. Temperature from 100 to 104. In 4 days he began to rally and the case looked more hopeful. A large bed-sore soon appeared with extensive sloughing. No improvement seemed to follow for some 7 or 8 months. Then the bed-sore commenced to heal, but was soon followed by local gangrene of the skin of his feet and legs, cystitis and orchitis with abscess of left testicle. | The operation revealed the fact that the 11th and 12th dorsal vertebræ were fractured and that the cord and membranes were completely separated for about 2 inches. The ends of the cord were degenerated. His limbs were atrophied, abscess opened in the knee-joint with extensive gangrene of the skin. He was taken to his home and died in about 2 weeks. He was in the hospital 314 days. |
| No. 10. Operated on April 7, 1893. Andrew A., aged 25. Total paraplegia, lacerated wounds of hands, arm, head and leg. Shock, pupils dilated, rapid pulse. | Operated immediately, comminuted fracture of 10th dorsal, membranes punctured and cord lacerated. Died 3 days after his admission. | | |
| No. 11. Operated on June 22, 1893. Carmin B., aged 47, mine laborer by occupation. Complete paraplegia from pelvis down. Labored breathing, pupils dilated, patient cyanotic, urine suppressed. | Operated at once. Fracture of the 3rd or 4th cervical vertebra, membranes and cord almost severed, considerable fluid escaped as soon as the skin was cut through. It was almost a compound fracture. Symptoms continued until death. Only a few ounces of urine were secreted in 4 days. Died in 4 days. | | |

# COMMUNICATIONS.

## ACETANILID VERSUS QUININE TO ABORT CHILLS AND FEVER; AND ACETANILID AS A DUSTING POWDER.*

BENJAMIN H. BRODNAX, M.D., BRODNAX, LA.

In 1890, I first used acetanilid in a case of catarrhal fever with convulsions, in an infant nine months old, with astonishing amelioration of all grave symptoms in fifteen minutes. My next trial of the drug was in intermittent fever in a family of three small children. The doses ranged from two to three grains, and when the time for the chills arrived the children were asleep and perspiring. I have employed the drug quite extensively, but it is especially in chills and fever that I desire to emphasize its great merit. My mode of using it is as follows:

If there is time before the chill I give from one and a half to two grains of calomel in quarter-grain doses a half hour apart. Then, whether the bowels have acted or not, I give, according to the age, from two to six grains of acetanilid twenty minutes or half an hour before the expected chill. Gentle perspiration, with sweet and natural sleep, usually promptly follow the administration of the drug, from which the patient wakens entirely relieved and ready to go about in half an hour.

When there is not time before the chill to administer the calomel it may be deferred until afterward; but the acetanilid may be given immediately before or during any stage of the chill or fever, with the happy result of promptly inducing sleep and gentle perspiration. Should the desired effect of the drug—viz., sleep and perspiration—not follow its administration within a half hour, a second dose of equal amount should be given.

The after-treatment consists of an acid tonic, viz.:

> Acidi. nitro. muriatici dil...f℥j
> Ferri sulphatis.....gr. lxxx.—M.
> This should stand for twenty four hours. S. Ten drops in water three or four times a day.

On Friday, October 19th, I was called to see a young man who had had "dumb" chills, with vomiting and severe gastric disturbances, for six days, the attack coming on daily at one o'clock and lasting until midnight. When I arrived, at seven o'clock in the evening, he was vomiting thick, glairy mucus, and was unable to retain anything on his stomach. I immediately administered hypodermatically one-quarter of a grain of morphine and gave six grains of acetanilid dry upon the tongue. He had one slight attack of vomiting soon after, but a little later fell into a sweet and a refreshing sleep, from which he did not waken until seven o'clock the next morning. As the next chill was expected at one o'clock he was ordered to take six grains of acetanilid twenty minutes before. No chill followed, and none have taken place since. The after-treatment with the "acid tonic" was pursued, as is always my custom.

I have now treated several hundred cases of chills with acetanilid, and without quinine, and report my success in the hope that others will be induced to give it a trial.

Acetanilid and boric acid, in equal parts, as a dusting powder, I have used extensively in ulcers, burns, etc. I find the powder especially serviceable in the excoriation of infants and fleshy people; with it I dust the funis of the newborn babe, while over the vulva of the mother I place a little cotton previously well dusted with the powder. Made into a paste with glycerin, I have used it in a vaginal tampon to allay uterine pain.

In the case of a female, sixty-one years of age, almost crazed with the itching from a pustular eruption that covered the lower part of the abdomen, vulva, and anus, the powder well dusted over the affected parts, after first moistening the parts with dilute carbolic acid, was followed by six hours of consecutive sleep. She was wakened by a return of the itching, and, rising, washed the parts and re-

* Read before the Philadelphia County Medical Society, February 13, 1895, by Dr. Oscar H. Allis.

applied the dilute carbolic acid and powder, with immediate return to sleep. A great improvement was observed the next day, and in a few days the parts were well. Previous to the application of the powder she had not slept well for several nights even with the aid of morphine.

Internally I have used it to correct a foul breath; also in dysentery and diarrhœa. When taken on the tongue and held in the mouth a few moments before swallowing, it has the effect of allaying the distressing thirst that accompanies fever.

## AN INTERESTING CASE OF RAPID SPEECH DEVELOPMENT IN ADULT, FOLLOWING OPERATION FOR TONGUE-TIE.*

G. HUDSON MAKUEN, M.D., PHILADELPHIA.

The patient whom I shall show you this evening is nineteen years of age, a farmer by occupation, and up to within eleven months he has been utterly unable to use articulate speech in a manner which could be understood. He had been examined by local physicians and had been made to believe that his trouble was of central or cerebral origin, and that nothing could be done for him. The feeling that he was thus cut off from this chief means of communication with his fellows had completely disheartened him.

He had attended public school with other boys, and with the aid of his friends at home had managed to make some progress in arithmetic and to acquire a very slight theoretical knowledge of our language. He seemed to understand a little ordinary conversation, and learned easy lessons in history and geography by having them read to him. He would attempt to talk and recite in school, but his teachers had to guess, for the most part, at the meaning of his jargon. For myself I do not recall a single word that was at all intelligible. The first time he came to my office he could not make the conductor on the train understand the name of the station at which he lived, and after frequent attempts he was obliged to write it out, which he could do very imperfectly, for his spelling was almost as bad as his speech.

With a history of this kind, and being deprived of that greatest of all means of mental development—speech—you will be prepared to believe that he had acquired a reputation, even among those who knew him best, for listlessness and stupidity. Indeed, his aunt, with whom he came, had given up all hope of making anything of him; but the boy, discouraged as he was, seemed determined to make one more effort, and he was thoroughly in earnest.

Upon examination of his vocal and speech organs I found only a slight post-nasal catarrh and some little hypertrophy of the faucial tonsils. Of course, I thought immediately of the probability of his being tongue-tied, but his aunt assured me that there was nothing of the sort. I found, however, that he could protrude the tip of the tongue scarcely beyond the outer margin of the lips. The tip seemed a full inch or more too short, and, strange to say, the frænum did not appear to be a very decided factor in holding it down or back, for in his attempts to protrude the tongue the frænum was not greatly stretched. The trouble seemed to be a muscular one, and this I believe to be the case. The anterior fibres of the geniohyoglossus muscle were too short, and prevented not only the protrusion of the tongue, but any other free action of that member. He could elevate the back part of the tongue and make the hard G sound or the NG sound, but he could make no sound whatever which required the placing of the tip of the tongue to the roof of the mouth or the upper teeth. He made the K sound for T and hard G sound for D. As an example, he said "ik" for "it," and when I asked about his parents he said they were "gay"—meaning that they were dead. Furthermore, there seemed to be no method in his speech; it

*Read before the Philadelphia County Medical Society, February 13, 1895.

was a mere jumbling of inarticulate and unintelligible sounds, and the expression of his face was in perfect harmony with his speech—vacant, staring, meaningless.

The boy being somewhat delicate, and his friends being decidedly opposed to operative measures, and the cause of the trouble being doubtful, I decided to study the case carefully before giving an opinion or recommending methods of treatment. I gave him some vocal exercises for a few days and watched the results, after which I clipped the frænum of the tongue well back.

I then put him in the hands of a teacher, who gave him, under my direction, several hours' vocal drill each day for several months, during which time he made considerable improvement in sounds and words which did not require free action of the tip of the tongue. By this time I was convinced that the trouble was entirely a local one, and that the boy was of more than average intelligence and well worth developing. I then decided to divide the anterior fibres of the geniohyoglossus muscle, and thus try to give to the tongue the necessary freedom of action. His people would not give their consent to etherization, for they were skeptical as to favorable results from any measures whatever. The boy, however, was desperate, and would submit to anything which promised relief. We took the matter into our own hands, therefore, and with cocaine anesthesia I made an incision under the tongue of three-quarters of an inch in the anteroposterior direction and one and one-half inches from side to side. There was considerable bleeding, which was easily controlled, and, of course, there was also some pain.

He came to my office each morning for five days thereafter, and I broke up little adhesions which had formed and practiced slight lingual traction. On the morning of the sixth day he came in a great state of excitement, and with much pain, which he referred to the region of his tongue and throat. The tongue was greatly swollen, filling the entire mouth and protruding between the lips. He had a temperature of 103°. The larynx became involved to the extent of threatening suffocation, and I thought it would surely be necessary to open the trachea, which I made all preparations to do, but after succeeding in giving him a brisk purge the inflammation gradually subsided and the breathing became less labored. He was confined to bed for ten days, after which time he practiced frequent lingual traction and vocal exercises directed toward a free action of the tongue. His improvement from this time on has been most wonderful. Here we have a young man, nineteen years of age, who less than a year ago could not pronounce intelligibly more than three words of our language, could not buy a morning paper or tell you where he lived, and could not give his name to save his life. What he can do to day, with your permission, Mr. President, I shall try to demonstrate to you. I shall ask him to recite in your hearing Brutus' speech against Cæsar.

### A New Antipyretic.

Tussol is the name given to a compound of amygdalic acid and antipyrine. Dr. Rehn of Frankfort-on-the-Main, has used the drug recently in quite a number of cases of whooping cough in children. He has found it useful in reducing the frequency of the paroxysms and mitigating their intensity, that its action is different from that of simple antipyrine, and that no untoward effects have been observed from its use. It is soluble in water, and as a corrigent raspberry syrup is better than milk. The minimum doses for children are as follows: Under one year of age, from three-quarters of a grain to a grain and a half, two or three times a day; from one to two years, a grain and a half three times a day; from two to four years, from three grains and three-quarters to six grains, three or four times a day; for older children, seven grains and a half, four times a day or more.

### The Inheritance of Insanity.

Dr. G. Fielding Blandford, President of the Physiological Section of the British Medical Association, took as the subject of his opening address, "The Prevention of Insanity." One of the most important factors in the etiology of the disease, he said, is heredity. Sir Benjamin Ward Richardson has made the assertion that insanity is transmitted through the male line, but the speaker held that the reverse is the case, the taint passing through the female line rather than the male. He did not, however, insist so strongly on this point, holding that the safest rule was that no one, man or woman, who had had an attack of insanity should marry.

# VARICELLA COMPLICATED WITH GANGRENE OF THE SCROTUM.*

CHARLES D. SPIVAK, M.D., PHILADELPHIA.

Jonathan Hutchinson was the first to draw the attention of the medical profession to a complication of varicella characterized by the development of gangrene of the skin and deeper tissues at the site of the eruption. Since his memorable article on "Gangrenous Eruption in Connection with Vaccination and Chickenpox" (*Med. Chir. Trans.* vol. lxv., p. 1), similar cases have been reported from England by Abercrombie (*Trans. Path. Soc. Lond.*, vol. xxxi., p. 333), Martin (*Brit. Med. Journ.*, 1881, vol. ii., p. 803), Howard (*Ibid.*, 1883, vol. i., p. 904), Jamieson (*Trans. Med. Soc. Edin.*, 1886-87, vol. vi.), Andrew (*Clinical Record*, 1890, vol. i., p. 63, and *Trans. Clin. Soc. Lond.*, vol. xxii., p. 79), Blowly (*Lancet*, London, 1885, vol. i., p. 987), Payne (*Trans. Path. Soc. Lond.*, vol xxxvi., p. 471), Crocker (*Med. Chir. Trans.*, vol. lxx., p. 397), and Stanifooth (*Med. Press and Circular*, London, 1890, vol. xlix., p. 37). The United States and Germany are represented in the literature on the subject by two authors each: the first by Woodward (*Pacific Med. and Surg. Journ.*, 1889, vol. xxxii., p. 197) and A. F. Büchler (*Amer. Journ. Med. Sci.*, 1889, vol. xcviii., p. 265, and the latter by Demme (*Wiener Med. Blätter*, 1892, vol. xv., p. 3) and Cassel (*Archive für Kinderkrankheiten*, 1894, vol. xvii., p. 371). Whether the children of other nationalities are exempt from this complication, or the cases have not been reported, I do not undertake to decide. So far as my researches go I could not find a single case in the French, Italian, Russian, or Spanish medical literature. The rarity of the complication in general, and the exceptional features of the case which came under my treatment in particular, justify me in reporting the same before you.

The patient was a boy of Russian parentage, aged two years, whose father and mother are healthy, with no scrofula or tuberculosis in family, and with five other children all well and healthy. Had had no serious illness previous to the attack of chickenpox. As I saw the case for the first time only on the eighth day of the disease I have to rely upon the data furnished by the parents, who proved to be tolerably good observers and quite reliable. On November 25, 1894, the appearance of the chickenpox was noticed for the first time; on the 26th the child became restless and had fever; on the 27th the fever increased, the child was delirious, and the scrotum became red and swollen. This state continued until the 30th, when the swelling extended to left inguinal region; a black spot, the size of a pin-head had appeared on the left side of the scrotum, and soon several others formed a circle around the original one and coalesced. On the following day another black spot appeared, a little further to the left on the scrotum, and "before one had time to look at it," as the parents expressed themselves, the process of deep ulceration and "eating up" commenced. On December 3d I saw the child for the first time. The child was well preserved and plump, as seen on the photograph and by its appearance now, and somewhat irritable. The penis, the scrotum, and the left inguinal region were very much swollen and tender. The left side of the scrotum was covered by blackish, muddy-looking crusts, and detritus covering about two-thirds of it and passing over the raphe to the right side. The smell was very offensive. The crusts and detritus were carefully removed and the tunica albuginea of the left testicle was exposed to the view, thus showing that the gangrenous process destroyed not alone the integument but also the dartos, the external cremasteric, and internal fascias, and the tunica vaginalis. There was a distinct areola around the ulcer. The existence of pus in the inguinal region was easily demonstrated by its fluctuation and also by the oozing from a very small spontaneous opening found about half an inch from the scrotum. The temperature was 101.6°, pulse 110. Pressure over the bubo gave pain, but the handling of the ulcer was almost painless. I washed the

* Read before the Philadelphia County Medical Society February 13, 1895.

parts with bichloride and applied the iodoform-gauze dressing and bandage. On the following day, when the bandage was removed, the ulcer was found to present a somewhat better appearance, but was still angry looking and covered with pus from the oozing aperture. The child was anesthetized by Dr. Rachel Skidelsky, and introducing the groove director through the opening I laid open the ingunial region throughout its length, as is seen on the photograph. I cleansed the wound thoroughly and packed it with iodoform-gauze. (At this juncture the photograph was taken, which shows the incision with the packing in it; the left testicle exposed and many spots of dried up vesicles all over the body.) The ulcer was dressed with bichloride gauze saturated in hydrogen dioxide, and applied a T-bandage. Of course the ulcer required a good deal of trimming of the dead tissues. I ordered two grains of quinine to be given in the evening and two grains in the morning. It was then that I noticed that three children in the family had varicella in different stages of development. There were no complications in the other cases.

On the following day the temperature fell to 99.2°; the child slept almost the whole night, the first time since it was taken sick; the ulcer and wound were clean and the gangrenous process checked. The local treatment was continued the same during the entire period of the regeneration of the scrotum, which took about thirty-five days. The repair is complete and admirable, as you can see on the child, leaving only a star-shaped cicatrix. No internal treatment was needed after the third day.

Through the kindness of Dr. J. S. Billings, Deputy Surgeon-General U. S. Army, I was enabled to trace the literature on the subject antedating the report of Hutchinson. Besides the mention by Hutchinson of two casts in Guy's Hospital Museum, which were named varicella eschorotica, and the case of Stokes described in 1807 in his *Dublin and Physical Essays on Eruptive Diseases in Children*, which he named pemphigus gangrenosa, and which, according to Hutchinson are to be regarded as cases of varicella gangrenosa, the following cases were reported and minutely described by their respective authors as varicella complicated with gangrene. Dr. Humphrey Storer (*Boston Med. and Surg. Reporter*, 1828, vol. i., p. 212), Steinthal (*Analekten.*, 1843), Laewenhardt (*Rheinische Monat. für Prakt. Aerzt.*, 1850), Dr. Frederick J. Brown, of Rochester (*Brit. Med. Journ.*, 1863, vol., ii., p. 420), and Dela Harpe (*Bull. Soc. Med. de la Suiss Rom.*, 1869).

---

### Treatment of Epilepsy.

According to the *American Medico-Surgical Bulletin*, Eulenburg recommends a combination of one part of ammonium bromide to two parts each of potassium and sodium bromides, to be given in a weak watery solution; the dose to be regulated by the number, character, intensity, duration and time of occurrence of the fits; also, the conditions presented in the interim, the average daily dose for an adult being from one to two drachms, but four to five drahms may be safely given if the patient be carefully watched, and to avoid stomach trouble it is preferable to administer the dose about half an hour after meals.

Intolerance may be overcome by beginning with small doses of bromide combined with arsenic and iron.

When a daily dose of the bromides sufficient to control the paroxysms has been determined, it should be rigidly adhered to throughout the treatment, and the bromides are, under all conditions, to be continued for three years after the last fit.

---

### For Ringworm.

Iodine has been found to be one of the most effective agents for destroying the parasite upon which this disease depends. An excellent method of applying it is the following: Thoroughly cleanse the scalp with soap and water. Dry perfectly, then apply a solution of one part of pure iodine in thirty parts of flexible collodion. Renew the application each day for four days. At the end of fifteen days renew the collodion, wash the scalp first with soap and water, then, after thoroughly removing the soap, wash with a hot solution of bichloride of mercury, one twenty-five-hundredth. After allowing the bichloride solution to remain in contact with the scalp for half an hour, wash with pure water, dry, and apply vaseline or zinc ointment. If necessary, repeat the application.—*Mod. Med.*

# TRANSLATIONS.

## THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.*

### ELECTRICITY IN UTERINE FIBROMAS.

Dr. Mally (*Annales de Gynecologie*, No. 10, 1894) reports on thirty-three cases of fibroma of the uterus which he has treated by electricity. In seven the symptoms wholly disappeared (menorrhagia); the results were less favorable in cases where the appendages had been injured during laparatomy; in one patient, who left off treatment, there was a salpingitis; in four cases he noticed an actual diminution of the size of the growth; in four there was no decrease in size, and in one a real increase. He describes two procedures for the application of electricity: a surgical and a medical application. The surgical, characterized by deep cauterization, he holds indicated in—

1. Fibromas that are increasing in size.
2. Fibromas with simultaneous disease of the appendages.
3. Fibromas that project into the cavity of the uterus and which will probably be easily enucleated.

Otherwise the usual measures (medical) are to be employed, with introduction of the positive and negative poles, with their well-known action.

### GALVANIC IGNIPUNCTURE IN LUPUS TELEANGIECTODES.

Dr. D. Majocchi (*Berliner Klinische Wochenschrift* No. 20, 1894) in a case of lupus teleangiectodes disseminatus of the lower extremities which was characterized by a great overdevelopment of the capillary vessels in the region of flat and slightly infiltrated plaques employed galvanic ignipuncture with very satisfactory results. Later in the disease these capillary ramifications enlarge so as to present a bluish and varicose appearance upon a red background.

### TREATMENT OF PLANTAR AND PALMAR KERATODERMIA.

Dr. Brocq (*Journal Des Maladies Cutanées et Syphilitiques*, No. 11, 1894) calls attention to the obstinacy and proneness of this disease to recur. Internally, large doses of arsenic are of service. Locally, the indurated patches may be softened with prolonged baths, poultices, rubber gloves, compresses of hot water, covered with impermeable protective; then the epidermis is easily removed by a scraper or the nails. This treatment is then best followed by local application of black soap until all the epidermis is detached and only the thin subcorneous layer remains; then a glycerole of starch to which a-twentieth of salicylic and tartaric acids have been added is of value. After employing the black soap he also advises the use of the following formula:

| | | | |
|---|---|---|---|
| Tartaric acid..... } | | | |
| Salicylic acid..... } | āā | 1 | o grs xv |
| Carbolic acid..... | | o | 50 " vijss |
| Resorcine..... | | 1 | 50 " xxijss |
| Lanoline ..... | | 18 | o 3iv, grs xxx |
| Vaseline ..... | | 7 | o 3j, 34 |

### ICTERUS AFTER THE USE OF MALE FERN AS A TAPE-WORM REMEDY.

Dr. E. Grawitz (*Berliner Kilnische Wochenschrift*, No. 52, 1894) warns against administering the extract of male fern-extractum filicis maris æthereum as a tænicide to those who are liable to liver affections, who are hard drinkers or have had syphilis, as this drug has a deleterious influence upon that organ, and may, in certain cases, lead to an interstitial hepatitis and which drug is possibly of significance in determining cirrhosis of the liver. Above all, he would not administer it at the same time with castor oil.

### PRURITUS OF THE VULVA.

Dr. N. Guéneau de Mussy (*Spit.* No. 21, 1894) praises in the treatment of pruritus of the vulva, the following formula:

| | | |
|---|---|---|
| Glycerole of starch..... | 20 | o 3v |
| Bismuth subnitrate ..... | 1 | o grs. xv |
| Bromide potash ..... | 1 | o grs. xv |
| Extr. belladonna..... | o | 25 grs. iv |
| Calomel ..... | o | 50 grs. viij |

Apply locally.

*In charge of the translator, F. H. Pritchard, M.D.

### TREATMENT OF CANCROID.

Dr. Brocq (*Journal Des Maladies Cutanees et Syphilitqiues*, No. 11, 1894) has observed the chlorate of potash and resorcine to be the remedies acting best in cancroids. In a diabetic male patient with granulating epithelioma of the prepuce he recommended local application of the finely powdered chlorate of potash and dressing with compresses dipped in:

| | | | |
|---|---|---|---|
| Chlorate potash | 50 | 0 | ʒ jss |
| Resorcine | 5 | 0 | ʒ j¼ |
| Distilled water | 500 | 0 | ʒ xv, ʒv |

Instead of this the following salve he also recommends:

| | | | |
|---|---|---|---|
| Resorcine | 1 | 0 | grs. xv |
| Chlorate potash | 3 | 0 | grs. xlv |
| Vaseline | 20 | 0 | ʒ v |

### GLYCERINE TO INDUCE UTERINE CONTRACTIONS

Dr. P. L. Ferrari (*Lo Sperimentale*, No. 36, 1894) after an exhaustive study of the question of the use of intra-uterine injections of glycerine to bring on uterine contractions, concludes as follows:

1. Glycerine injected into the uterine cavity to induce premature labor or abortion, is not reliable, in its action, neither as to the appearance of the pains, their intensity nor duration.

2. Glycerine is harmful and actually dangerous on account of the changes which it causes in the blood and the kidneys and it should be absolutely excluded in those cases where a renal lesion is either diagnosed or suspected.

3. Glycerine may be injurious to the child or even fatal.

### INTESTINAL COLIC IN CHILDREN.

Dr. Ciro L. Urriola (*Rivista Clinica E Terapeutica*, No. 12, 1894) recommends highly the following mixture, in the colic of children:

| | | | |
|---|---|---|---|
| Tr. Belladonna | gtts. xx-xl. | | |
| Destilled cinnamon water. | 60 | 0 | (ʒij). |

A teaspoonful every hour until relief follows.

In treating the constipation which is the chief cause of the colic of these little patients he administers cod-liver oil in doses of three to five teaspoonfuls a day.

Dr. Escherich (*Ibidem*) in the treatment of chronic constipation accompanying chronic tuberculosis of the peritoneum or of the intestines in children, advises the use of the following formula:

| | | | |
|---|---|---|---|
| Sulphate atropine | | 0 | 003. |
| Water | 100 | 0 | (ʒiij. ʒj). |
| Gum mixture | 20 | 0 | (ʒv). |

To obtain the desired effect this preparation must be long continued. One may also at times administer a laxative. During the whole time that this mixture is given the pupils should be carefully watched.

### SALVE FOR LUBRICATING SOUNDS.

Prof. Guyon (*Norsk Magazin for Lægevidenskaben*, No. 12, 1894) employs in his clinic, the following salve as a lubricant for urethral sounds:

| | | | |
|---|---|---|---|
| Soap | 50 | 0 | (ʒjss). |
| Glycerine | | | |
| Water ää | 25 | 0 | (ʒvj). |
| Bichloride mercury | 0 | 02 | (gr. ⅓). |

This salve is aseptic, does not irritate the urethra and renders catheterization easy.

### CRÉDÉ'S PROCEDURE IN THE PLACENTAL STAGE OF LABOR.

Dr. Pelzer (*Hospitals Tidende*, No. 50, 1894) has collected one thousand cases treated by Crede's method a half hour after birth of the child and compares them with five hundred from the same institution treated by Ahlfeld's method—the placenta removed after two hours by a light pressure upon the uterus—finding that severe hemorrhages are far more frequent, puerpural febrile complications of the same percentage and a slightly less retention of membranes with the expectant treatment.

### TRAUMATIC PULSATING EXOPHTHALMOS.

Dr. Hansen (*Muenchener Medicinische Wochenscrift*, No. 51, 1894) observed a woman who after being run over by a wagon developed signs of a fracture of the base of the skull and pronounced and pulsating exophthalmos of the right eye which, on auscultation, yeilded a blowing sound. This form of exophthalmos is, as a rule, the consequence of an arteriovenous aneurism of the cranial cavity from rupture of the internal carotid into the cavernous sinus. He intends to treat it by long continued compression of the carotid or if this fail, by ligation of that artery.

### A NEW WAY OF ADMINISTERING COD-LIVER OIL.

Dr. Dietrich (*Revue Internationale de Medicine et de Chirurgie Pratiques*, No. 19, 1894) has succeeded in masking the disagreeable taste of cod-liver oil by the following formula:

| | | | |
|---|---|---|---|
| Cod-liver oil | 1000 | o | ℥xxxj ℥ij |
| Essence lemon | 5 | o | ℥j ¼ |
| Essence Clove | 2 | o | grs xxx |
| Essense peppermint | 1 | o | " xv |
| Vanilline | 0 | 10 | " jss |
| Cumarine | 0 | 01 | " 1 1-6 |

The cumarine and the vanilline are dissolved in the essential oils which are slightly warmed and this solution is mixed with the oil.

---

### SALICYLATE OF SODA BY THE RECTUM.

Prof. V. Ziemssen (*Wiener Medizinische Presse*, No. 52, 1894) in those cases where there is a peculiar idiosyncrasy with regard to the salicylates advises giving it in clysters. Absorption takes place from the rectum nearly as promptly and with as good therapeutic results as though it were given by the mouth. From two to three grams (grs. xxx—xlv) at a dose are dissolved in fifteen to twenty grams (℥ iv—v) of warm water and this injected; it may be repeated if necessary. The disagreeable symptoms of an overdose, as ringing in the ears and sweating also are observed with this method of administration, but the nausea and disgusting aftertaste are avoided. He can also recommend giving other disagreeably tasting remedies by the rectum as, for example, the different preparations of squills. As to the percutaneous use of the salicylates by means of a salve applied to the painful joints he also thinks quite favorably of it and has obtained with it good results. Absorption is accelerated by addition of turpentine to the formula, though it is not absolutely necessary for it will take place with the pure acid alone. He uses the following formula:

| | | | |
|---|---|---|---|
| Salicylic acid<br>Oil turpentine | āā | 10 | o ℥ijss |
| Lanoline | | 30 | o ℥j |
| Vaseline | | 50 | o ℥jss |

---

### TREATMENT OF ACUTE TONSILITIS.

Dr. Miles (*Rivista Clinica E. Terapeutica*, No. 12, 1894) advises in acute tonsillitis the following treatment:

| | | | |
|---|---|---|---|
| Essence Eucalyptus | 1 | o | gtts xv |
| Spirits Camphor | 5 | o | ℥j ¼ |
| Tr Guaiac | 15 | o | ℥iv |
| Glycerine | 10 | o | ℥ijss |

Every hour or two pour ten drops of this mixture upon a lump of sugar which is allowed to melt in the mouth.

When the fever is intense the following powders are of service:

| | | | |
|---|---|---|---|
| Acetanilid<br>Phenacetine | āā | 1.25 | (grs xviij) |

Sufficient for six powders. One every four to six hours.

At the same time one may apply externally to the neck the following:

| | | | |
|---|---|---|---|
| Tr. Lobelia<br>Tr. aconite root | āā | 8 | o ℥ij |
| Chloroform | | 10 | o ℥ijss |
| Essence Turpentine | | 12 | o ℥ij |

---

Dr. L. Emmett Holt, in *Archives of Pediatrics*, summarizes the treatment of diphtheria as follows:

1. Germicidal treatment, preferable by the use of a strong hydrochloric acid, used early to be effectual; especially valuable in cases beginning on the tonsils.

2. Local cleanliness by the use of a weak antiseptic solution in the pharynx.

3. Nasal syringing with the same solutions in every case where there is nasal discharge.

4. Alcoholic stimulants begun as soon as the first systemic effects of the poison are seen, and in very severe cases pushed to the point of tolerance.

5. Calomel fumigations as soon as laryngeal symptoms appear.

6. Intubation in laryngeal cases not relieved by fumigations.

---

### Ipecacuanha as a Uterine Stimulant.

Drs. Stillmark and Utt, of Russia, after a series of experiments upon parturient women, have demonstrated that ipecacuanha is a valuable stimulant to the contractions of sluggish uterus during labor. They administered three successive doses of ten drops each of wine of ipecac at intervals of ten minutes. In from twenty to thirty minutes the contractions of the uterus became of normal strength and duration. In but one case were the contractions of the uterus noticed to be spasmodic in character, and the observers conclude that ipecacuhanha possess much less tendency to cause tetantus of the uterus than ergot.—*La Semaine Medicale.*

# THE MEDICAL AND SURGICAL REPORTER

ISSUED EVERY SATURDAY

Address all communications to P. O. Box 843, Philadelphia, Pa.

HAROLD H. KYNETT, A.M., M.D.
Editor.

RODERIC C. PENFIELD
Publisher.

Editorial Offices, 1026 Arch Street, Philadelphia, Pa.

Entered as second-class matter at Asbury Park, N. J.

TERMS:—Three Dollars a year in advance. Sent four months on trial for $1.00.

REMITTANCES should be made payable to the Publisher only, and should be made by Money Order or Registered Letter.

NOTICE TO CONTRIBUTORS:—We invite contributions of value to the profession, and if published originally in THE REPORTER such will be paid for at liberal rates, or a limited number of copies of THE REPORTER will be supplied, as the author may elect. Hereafter where reprints are desired writers are requested to make a note of that fact on the first page of the MS., but must order reprints directly from the publisher, who will supply the same at cost rates. Contributors should inclose stamps for postage, that the articles may be returned if not found available.

SATURDAY, MARCH 30, 1895.


## EDITORIAL.

### MEDICALLY PURE IN ART.

In another column we reprint a letter to the editor of the *Medical Record*, from an honored member of the American medical profession, anent the subject "Scientific versus Obscene Medical Literature."

Everything considered, the New York Academy of Medicine is, perhaps, the most influential and aggressive medical organization in this country. It has not hesitated to exert its influence in public affairs when the opinions of medical science were important for public good. No further explanation for the medical supremacy of New York is necessary, when there exists a profession whose representative men devote time and thought to the enlargement of public weal rather than to the curtailment of private competition. Whatever may be the local differences, and however intense may be individual or factional feelings, the profession of that city is united for medical New York. It furnishes a significant lesson for other aspiring—or expiring medical centers, Philadelphia not excluded; and for selfish considerations if for nothing higher. It shows the unwisdom of becoming rapt in a too utterly soulful contemplation of the picturesquely moss-bedecked monuments of what has been, and indulging in an æsthetic languor superinduced by the exhalations of a ponderous dignity, in existence purely subjective. The mountain does not seek Mohamet in the dawn of the 20th century.

Dr. Jacobi's proposed measure may not be ideal but it is practical. It is an effort to advance and THE REPORTER gives it cordial approval.

A closely allied evil, although operating more within professional limits, may be denominated "Scientific versus Obscene Medical Illustration"—a distinction as well defined in pictures as in letter-press.

It is needless to urge the utility, and even the necessity of illustration in medical literature. At the very best, medicine does not afford a field rich in subjects suitable for "high art" in its general application.

Medical illustrations may be classified, according to the purposes of their produc-

tion, into three groups. Those familiar with medical literature can promptly refer to its proper category every illustration presented, without a detailed description of the groups more than may be inferred from a candid answer to the question, Why this illustration?

The first group, which may be said to include the major part of medical art, is presented purely to aid in accurately comprehending the meaning of the context. Such illustrations often are as necessary to the proper elucidation of the subject-matter as are figures to a successful demonstration of problems in geometry. This is the legitimate function of art in medical literature, and the more accurately and elegantly it performs its office, the greater becomes its value. As might be expected, this group contains almost all diagrams and conventional figures, colored plates, and the greater portion of hand-wrought illustration. Contrary to the popular impression, a large share of process-reproductions of photographs from life are excluded from this first group, and for reasons obvious when the mechanical difficulties to be overcome are taken into consideration.

In the second group will be found such illustrations as are made to sell a book, or perhaps to gratify some little personal vanity. Instances of the seductive representations of canvassers who enlarge upon the magnificent pictorial display of the forth-coming work and discourse learnedly concerning "half-tones" and "photo-gravures" etc., etc., while meditating a raid on the doctor's pocket-book—such instances have become every day incidents in the lives of most medical men, especially distasteful to those who have subscribed in haste to repent at leisure. Not infrequently it happens that illustrations of this class are not only useless but are obscene—that is to say they rank very high as specimens of "pure (!) art". To this class belong also those illustrations which are sometimes used to enlighten the darkened understanding of medical men as to the applications of office-tables or other paraphernalia devised for the peculiar needs of medical practitioners. We have never yet seen a picture of this class which the wildest stretch of the imagination could regard as artistic, while in most cases it would be base flattery to call them vulgar. As to the protraits which exist mainly for the gratification of some little personal vanity and the desire to preserve to posterity the counterfeit presentment of one ambitious for fame, such pictures are generally as harmless as they are useless, but occasionally they bring retribution out of all proportion to the fault committed. A recent instance of "vaulting ambition, which o'erleaps itself, and falls on the other," the ambitious one, who, "only reaps from the hopes which around him he sows, a harvest of barren regrets," is found in the case of a brilliant young gynecologist whose features will be remembered by the readers of the twentieth century because of an incongruous association of ideas, no matter what visions of power and excellence the mention of his name may call up. This unfortunate individual had the imprudence, in some artistic production peculiar to his special work, to permit the foreground of some destinctive illustrations to be filled with most excellent photographs of himself, at the same time the only other striking feature in the group being to say the least, embarassing. He can derive no comfort from the situation, for the portraits are practically useless for any other purpose.

For the third group of illustrations occurring in medical so-called literature, but one reason may be assigned—as our Southern friends might express it, "pure, low-down on'riness." This style of art will ofttimes be found interleaving the advertising pages of some medical periodicals, in other respects not necessarily disreputable. For these illustrations the

very best that may be said is that they are obscene, and that under any circumstances they are unpardonably out of place in the pages of a medical journal, no matter how refined artistically or how pure in art aspiration such a journal may be. Undoubtedly these publications are under the ban of federal law even when construed most liberally. Their suppression would benefit medical science and medical literature would never notice their disappearance.

## "SCIENTIFIC VERSUS OBSCENE MEDICAL LITERATURE."

*To the Editor of the Medical Record:*

SIR—Under the above heading you published in your late number an editorial, which presumes to believe that for some reason or other, medical literature could be excluded from its present mail privileges if obscene literature were, through the passing of a strict and special law, prevented from enjoying them.

"Permit me to copy the wording of the bill proposed by me for the consideration and acceptance of the Medical Society of the County of New York, and of the New York Academy of Medicine. They were as follows:

"'Be it enacted, etc.,

"'That medical books, pamphlets and circulars, the contents of which are of a character not proper for general and indiscriminate perusal or circulation, shall not be admitted to nor transmitted through the mails unless enclosed in sealed envelopes or wrappers, and prepaid at letter rates of postage, *or unless addressed for delivery to or in care of physicians, surgeons, medical schools or colleges, or students in such schools or colleges, or to dealers in medical publications, and directed to them as such.'*

"It appears, Mr. Editor, you overlooked the last clause of the proposed bill altogether. If it were passed no medical journal or book would be interfered with, indeed, medical men and students, schools and dealers, would still enjoy the advantage of receiving, free of cost, their advertisements of 'Dr. W., female specialist,' of the 'Power Wafers,' of the 'Constitutional Tonic Wafers,' of the 'Way of Escape,' etc. It is true our boys and girls would not so easily be reached by the miscreants, as hitherto. Nor would they be told where the office can be found, and when, and at what price, where their bodies may be defiled, and their souls contaminated. A prominent postmaster in the United States received the following note from a father: 'The enclosed disgusting pamphlet was received through the mails by my son (fifteen years of age) yesterday. I do not know whether it is a violation of the postal regulations to use the mails for transmission of matter of this kind, but I consider it decidedly indecent and demoralizing.' This note was accompanied by a glaring circular describing 'how the celebrated Sultan's or Turkish wafers came to be introduced to Americans.' It was the same postmaster who suggested to me the bill as printed above. It is at present in the hands of the Hon. E. J. Dunphy, a representative of this city, who is a member of the House Committee on Post Offices and Post Roads. I do not say it is the best possible bill, but it is a better one and more efficient than you supposed it to be in your editorial of last week, and does not in the least interfere, as you will now admit, with the unhampered circulation of *medical* journals, magazines, pamphlets, or books. It will, when passed, protect to a certain degree against the filthy sheets disseminated by quacks as privileged mail matter.

"You, Mr. Editor, and your colleagues of the medical press, have great facilities in impressing and directing the conscience of the medical profession and the public at large. As that is so, your duties and responsibilities are just as great, and I fully believe you will benefit the community by again studying, and then recommending (amended, perhaps), and urging upon the representatives of the people, the bill introduced by me at the suggestion of a gentleman who had great opportunities to learn of the vast amount of obscene

literature distributed over the country, under the protection of the law of the land." Very sincerely yours,

February 26, 1895. A. JACOBI, M.D.

["After this explanation we not only agree perfectly with our distinguished correspondent, but give the measure our heartiest endorsement.—ED. MED. REC."]

# ABSTRACTS.

## A CASE OF ANESTHESIA WITH DEATH, AND ATTEMPTED EXTORTION SUCCESSFULLY RESISTED.*

EDEN V. DELPHEY, M.D., NEW YORK.

Among the many trials, troubles, and tribulations of members of our profession, is the one wherein some designing and unscrupulous person thinks he sees a short road to wealth by mulcting the family physician in a suit for damages.

Having recently, with a brother practitioner, been the victim of such an attempt, having together successfully resisted the attempts at extortion in a court of law, and being informed that no case of this kind and character has ever occurred in this State, we think it best that a statement of the facts be placed on record.

On February 13, 1892, Dr. A. H. Goelet of this city asked me to go with him to see a patient and perhaps to give an anesthetic for the purpose of amputating a gangrenous finger. On arriving at the patient's residence and after removing the dressing we agreed that it would be inopportune to operate at that time. On the 19th of March, following, while calling at the doctor's office, the patient came in and together we discussed the operation which was set for the following day, on which day, the 20th, we went to the patient's residence, began to give the anesthetic, and the patient died. Inasmuch as the facts and circumstances relating to the administration of the anesthetic, the attempts at resuscitation, etc., were brought out in the suit for damages, and are clearly and concisely stated in the hypothetical question, attorney's address, and judge's charge, they will be recounted later in that manner.

A few days after this unfortunate occurrence, we were each visited by a representative of a so-called "Society for Protection from Personal Injury," who stated that a suit was about to be begun and tried to induce us to compromise the case, but knowing we had done no wrong, regretting the misfortune as much as any one, and having the welfare of other members of the profession at heart as well as our own, we declined to do so. Some little time later we were again visited by another representative, who was very arrogant and abusive in his endeavor to extort money.

The trial, after many days, finally began in the Supreme Court before judge Truax, on Tuesday, April 24, 1894, and ended Friday, April 27, 1894, the jury bringing in a verdict in our favor.

The experts for the defense were: Drs. T. Gaillard Thomas, William T. Bull, Bobert Abbe, J. West Roosevelt, Herman J. Boldt, Edwin B. Cragin and Ferd C. Valentine, and the hypothetical question was as follows:

### HYPOTHETICAL QUESTION.

Q. Assume that a patient of about 52 or 53 years of age had gotten a splinter in the forefinger of his right hand; that it affected the bone, that gangrene set in, that he had septic symptoms, that he went to a physician's office one evening to have his hand dressed, and on examining it, the physician found that the bone could be taken out without giving an anesthetic, but he said he would not be able to bear the pain of it without an anesthetic; that the physician made an examina-

*Read before the 11th Annual Meeting of the New York State Medical Association, October 9th, 1894.—From the Amer. M. So Bul.

tion of his heart, his lungs, and his urine, and found that they were normal; that the physician attended with an assistant who was accustomed to give anesthetics to perform an operation of amputating the diseased finger; that while the physician was preparing his instruments the patient remarked: "Doctor, you are not going to give me chloroform, are you?" and the physician told him he would give him chloroform only in the beginning, as he would need less of the anesthetic; that the patient said nothing more; that the assistant also made an examination of his heart and lungs and was present and watched the physician when he made an examination of the patient's urine and coincided with his opinion of the results found by such examination, and that urine contained neither albumin nor sugar, and was normal. That the assistant asked the physician if he should commence with chloroform, and the physician said "Yes," and that then the patient was lying on the bed, partially undressed, prepared for the operation; that chloroform was administered by means of an Esmarch inhaler, and that the chloroform was dropped, drop by drop, on the inhaler from above; that about a half and not more than a fluid dram was used; that during the inhalation of the chloroform the patient began to resist, and threw his arms about the bed; that the physician sat on the side of the bed and took hold of the wrist of the sore hand so he would not injure it; when he became quiet the physician turned away to prepare his instruments, and while doing so he heard the patient breathing stertorously, that chloroform was laid aside for about one to two minutes until there were signs of returning consciousness and the stertorous breathing had changed to quiet and normal breathing. That either was then substituted for chloroform, and administered by means of a cone made of folding paper and towel, that shortly after the assistant asked the physician to help him, saying that the patient had stopped breathing. That the physician went quickly to the opposite side of the bed, and with the assistance of another person in the room, elevated the patient's feet and suspended his head and shoulders over the side of the bed, so that the assistant could make efforts at artificial respiration. That the assistant worked on the patient to produce artificial respiration, by the assistant grasping him by the elbows, pressing them forcibly against the chest, then extending them over the head, pretty well back, and repeating this performance about twenty times a minute for about half an hour, but without avail, that only after the heart had ceased to beat were efforts to resuscitate discontinued.

Now, in your opinion, did or did not the physician and his attendant or assistant use the proper and usual course adopted by physicians and surgeons in such cases?

A. Yes.

Assuming the same state of facts, did or did not the physician and his attendant or assistant practice and observe the usual methods generally and ordinarily adopted by physicians and surgeons in such cases?

A. Yes.

Assuming the same state of facts, did or did not the physician and his attendant or assistant practice and observe the usual methods generally and ordinarily adopted by physicians and surgeons skilled in performing such operations?

A. Yes.

Assuming the same state of facts, did or did not the physician and his attendant or assistant practice and use the care and skill ordinarily used and employed by skilled physicians and surgeons in administering chloroform or either?

A. Yes.

Assuming the same state of facts, in your opinion, had or had not the physicians committed malpractice?

A. Certainly not.

The attorney for the defense was Albert C. Aubery of this city, and after thanking the judge for his fair decisions and the jury for their patient attention, reminding them that His Honor was judge of the law and they were sole judge of the facts, and that their responsibility was no light one, as on their decision hung the future professional hopes and prosperity of the defendants, he said:

Now, gentlemen, what is this action? By whom is it brought? Against whom is it brought? And what will be the result of your decision? These are questions to which I propose to call your attention, requesting the same degree of attention on your part to what I may say that you have already given to this case.

This action, gentlemen, is to recover

the sum of $5,000 from the defendants by the plaintiff for alleged malpractice.

The plaintiff is the widow and administratrix of M. L., deceased. She sues as such administratix, under the statute of the State of New York, claiming that amount of damages—mark you, gentlemen, damages!—for wrongfully causing the death of her husband. She claims that the defendants administered to her husband chloroform, a deadly anesthetic, in their capacity and occupation as physicians and surgeons, so negligently and unskillfully as to cause his death, thus depriving her and her children of their only support. She also claims that chloroform was administered to her husband by the defendants contrary to her husband's expressed request, and contrary to her request and that of their children. The husband of this plaintiff was afflicted with gangrene of the forefinger of his right hand. The finger was to be amputated. The defendants were employed to perform the operation. They deny all charges of negligence, or of other improper conduct. I think, gentlemen, you will agree with me that I have made a fair statement of the case, and by whom it is brought.

As to the question against whom it is brought, you, gentlemen of the jury, have seen them here. Ever since this case has been on trial—now its fourth day—the defendants have been in court, their future professional reputation dependent upon your decision. They fear not the result, for they conscientiously feel that there is not a man on this jury who will not decide this case under the solemn oath he took, when he was sworn as a juror, to render a true verdict upon the evidence.

After referring to the positions of the defendants in the community, he continued:

This suit, gentleman, is not brought against a branch or limb of the medical and surgical profession, but against the root and tree of that honored profession. It is a blow struck at its very foundation. A blow which, if you shall hold is well aimed by your verdict for the plaintiff in any sum, however small, means a deadly blow to that profession. But I believe better things of you. I have in you full confidence that you will render a verdict which will send both of these defendants back to the bosom of their respective families, now anxiously waiting their return, to gladden not only their hearts, but one which will be flashed over the electric wires, binding State to State as one common brotherhood, to every medical society in this country, that these defendants are not guilty of malpractice; that they are not malpractitioners.

What profession, gentlemen, is more honored than the medical? I know of none. The physician comes nearer to the bosom of your family and life than any other of the learned professions. While the minister and the lawyer in turn have their arduous work and duties, yet the medical profession is the one you look to so that you may have a clear head and perfectly healthy body for your daily labors. It is he who holds the secrets of your life. Your physician, in order to carefully administer to your every want and need in time of sickness, should know your whole system and life from the cradle. It is to him you reveal your whole life and deeds so he may judge how properly to relieve your sufferings so you may attend to your daily duties; and in your last hours on earth, he is often found to be the best comforter and sympathizer with those whom you may leave to mourn. What profession is more noble?

Gentlemen, there is more at interest here than if this were an action for debt. These defendants are not in debt to this plaintiff. They do not owe her a cent, and although this suit is one to recover money damages, the effect of a judgment for any sum against these defendants is far-reaching and significant. It means that they have been careless, negligent, unskillful, and untrustworthy in their professional conduct. This is the charge. Their professional reputation is attacked! This is a suit for malpractice, gentlemen; do not forget that! Now, what is malpractice? Let us see if the charge has been established, and if these defendants are malpractitioners. Malpractice is an improper discharge of professional duties, either through want of skill or negligence. In other words, it is negligence. That is a fair definition. Being an action for malpractice, it is one in tort, as we lawyers say. Now, the medical man holds himself out to the public, that he possesses the ordinary skill requisite for reasonable success, and that he will attend to the case put in his charge with due care. Hence, negligence in the medical man is a viola-

tion of the obligation that he impliedly enters into when he accepts charge of a patient, which obligation enjoins care and caution in what he does and what he omits to do.

He then explained that the burden of proof rested with the plaintiff, and commenting on the evidence and the results of the autopsy, which were "pulmonary œdema, pachymeningitis, old adhesion of lung on left side, kidneys show some changes, gangrene of the first finger of the right hand," said:

You will remember that the plaintiff's case was hanging by a hair, and it was only because I saw the trial was about to terminate by the withdrawal of a juror, resulting in a mis-trial, that I consented, in order that these defendants should have an opportunity to be heard, to admit that if Dr. Walsh, who had made the autopsy, and who is at present on the high seas, was in court, he would testify that the autopsy disclosed just what I have stated to you.

* * * * * * On behalf of the plaintiff, a Dr. —— was called to give expert evidence. He said he resided at —— avenue, in this city. He said he graduated from the University at Vienna; that he came to this country in 1875, and graduated in 1884 from —— College, in Chicago. In answer to a question of the plaintiff's counsel, he testified that no conscientious physician would administer chloroform to a patient having incipient disease of the kidneys. This was the counsel's climax. The height of this case had then been reached. The witness submitted most unwillingly to cross-examination. You will remember how I asked him question after question as to what effect chloroform would have upon the human system. Many books of standard medical authority —books which he was compelled to admit were standard authorities, whether he had ever seen them or not—were read to him, paragraph after paragraph, wherein all the authors had written and asserted exactly the opposite to what he had testified to. The only way in which he could crawl from the ridiculous position which he had assumed, was to say, "I don't agree with the author." He put himself up as authority against them all. Yet he had to admit, although he had held the position of a Coroner of some obscure place out in the Western part of this country, that he has had deaths in his practice while he administered anesthetics. What could be his defense in case a suit for malpractice should be brought against him, when all the standard medical authorities would be read in evidence, as against the method he had adopted or the remedies he had used? I confess I do not know. I fear he would have to throw himself on the mercy of his accusers, and beg. Contrast him, as a witness, and his testimony, with all the standard medical authorities here produced; contrast him and his testimony with the high character and reputation, city, State, and national, of Drs. T. Gaillard Thomas, William T. Bull, Robert Abbe, J. West Roosevelt, Herman J. Boldt, Edwin B. Cragin, and Ferd. C. Valentine, called to the witness-stand by the defendants—witnesses whose very words, thoughts, and advice are sought after by the learned of the medical profession. What did those eminent medical college instructors and hospital surgeons say? You, gentlemen, have heard how they have ridiculed him. Not one agreed with him—not one. Some simply said "No," when asked if they agreed with him; others said, "It was absurd." I challenge the plaintiff's counsel to produce another man of any medical knowledge who will testify that he agrees with him. He said no conscientious physician would give chloroform to a patient who had any kidney disease. The authorities read to you and the witness said, "Do not give ether." Would you, or any reputable physician, believe —— and give ether, when all the authorities tell you in plain words not to give ether, but affirmatively say, give chloroform? I will admit doctors do not always agree. It is not natural that they should. Some physicians will give chloroform in any case. Some will give ether in any case. The evidence has demonstrated that; but not a single expert witness testified that he should not give chloroform when the patient had any kidney disease. I think I can fairly dismiss —— as a witness in whose testimony you can place no degree of confidence or credit.

Now, gentlemen, what more did those eminent physicians and surgeons—men of national reputation—testify to? You will remember the long, hypothetical statement reciting all the facts proved in the case and the questions which followed it. All

the witnesses—yes, all, not a difference between any one—testified that the defendants were not malpractitioners, that they followed the best practice, and used all the care that could be used. They followed the usual course skilled physicians and surgeons follow in such cases; that they were not negligent in their practice in any respect; that their treatment was proper in every respect; that they all approved of etherization by beginning with chloroform.

Now, gentlemen, we will turn our thoughts to the family deprived so suddenly of its head. Mr. M. L. had a gangrenous finger. The defendant, Dr. Goelet, was his family physician, and on March 20, 1892, attended to amputate the finger with Dr. Delphey, who was to administer the anesthetic. An examination of Mr. L., the patient, as you have heard testified, was made in the usual way and manner the day just prior to that set for the operation. Under the anesthetic agent, he died. The defendants deplored and greatly regretted the death. It was an accident, an unforseen and unexpected event, which no finite being had any reason to expect. The event is greatly to be regretted by all. But, gentlemen, this is not a case of charity. No one would be more liberal to aid and assist the afflicted family in case of need than their family physician. But when that trusted, competent, and skillful family physician, and his able assistant, are attacked unjustly for malpractice, and proclaimed to the world to be malpractitioners, there was no other course left them to defend themselves, their honor, their integrity, their ability, their lifelong study, their professional reputation. That is what is at stake in this action.

There is an element in this case to which I must call your attention. You have doubtless observed, gentleman, that the plaintiff's counsel, by all the pertinacity he could possibly bring to his aid, insisted that these defendants should not testify in this case in their own behalf. He based his objection to their testimony on the ground that the code relating to legal practice prevented physicians disclosing any information obtained in their professional capacity. You will remember when Dr. Goelet was called by me as a witness, the plaintiff's counsel at once stated his objection, and made a preliminary examination of the doctor, to ascertain whether the information which he obtained and was about to testify to was obtained in his professional capacity as a physician. The doctor answered that it was. Then the counsel's objection was formally stated to the court, to wit: That the doctor was not a competent witness, as the information was sacred, and he should not be permitted to testify. What was that done for, gentlemen? The evidence on the one hand had been given. Evidence had been presented that the doctors, these defendants, did and said this and that, and yet the counsel asked His Honor, presiding over the trial of this most important case, to decide that the defendants could not testify, virtually clasping and fastening over the mouth of these defendants a sold mask to prevent them from giving their version of the unfortunate accident. Oh, no, gentlemen; he was unsuccessful! His objection was promptly and justly overruled, and the proposition decided adversely to him. Then each of these defendants told in turn all that each of them had said to the deceased; what the deceased had said to them; just what they did, and how the unfortunate death of Mr. L. happened. I will not recite it to you. You have heard all the evidence, and wherever there is any difference of question of fact presented by the evidence you are to decide it. What is more reasonable than the defendants' position that an unfortunate accident had happened, for which they, in law, are not responsible?

You have heard the witnesses testify that death will happen suddenly from chloroform, and also from ether, even with the utmost care on the part of the surgeon. There is no dispute of that fact. I have shown you by evidence that all care was used by these defendants. The anesthetic was administered in a manner approved by the best medical authorities. I have demonstrated that these physicians were justified in administering the anesthetic as they did. What now remains? Your verdict in their favor. That is now asked, and justly so. I am about to leave the case of the defendants with you. The curtain of this trial is being dropped, and when submitted to you by His Honor's charge, we will await your verdict. What will that verdict be? We feel confident it will be for the defendants. Think of it

carefully, gentlemen. What will a verdict for the plaintiff mean? Let me tell you in a few words. As this is an action for damages in tort, it can be followed by an execution to be issued against the person of these defendants to incarcerate them behind prison bars. It will be remembered by every surgeon in this land, and no surgeon will dare give an anesthetic agent until an iron-bound contract has been signed by the patient, holding the surgeon blameless for all consequences. Think of it, gentlemen; a verdict for the plaintiff! One of you, who may render such a verdict in this case, may be injured in a few days. You may be seriously injured; amputation may be necessary to save your life. You are in great pain, and suffering severely; and the injured member, be it a foot, a hand, or a finger, must be amputated to save your life. Your life's blood is slowly but surely dropping away. You exclaim: "Doctor, I can't stand it any longer! Hurry and give me something to relieve the pain, and amputate!" All is ready for the operation, but your physician suddenly remembers the case of L. against Drs. Goelet and Delphey, in which the jury decided against the defendants. Then your physician tells you, "Not yet; you must wait until I can see my lawyer, and have a contract prepared for you to sign, to protect me in case of an accident of any kind." In the mean time, you lie suffering, perhaps dying. Think, gentlemen, carefully, what results a verdict for the plaintiff in this action will bring.

And now, gentlemen, I am about through. In you we have all confidence that the case is in good and careful hands. In leaving with you this case, I must call your attention to one word in the lexicon more bright than any star in the constellations. I think I can now see it standing out in your attentive and watchful eyes, and that word is that ever far-reaching and effective word, "Justice." Do justice in this case, and as the years roll on and your time comes to leave your dear ones behind you, may you never, never have any cause to regret the verdict given by you in this action. In all sincerity, in all hopefulness in the right, and that justice will prevail, I have confidence in asking you to return a verdict for the defendants.

JUDGE TRUAX'S CHARGE.

Gentlemen: This action is brought by the administratrix of M. L., deceased, to recover compensation for the death of her husband. She alleges that, on the 20th day of March, 1892, the defendants, contrary to the repeated objections and expostulations of M. L., administered chloroform in such quantities as to cause his death on that day, and that such death was due solely to the improper and unauthorized administration of chloroform carelessly and negligently given, as aforesaid, and to the want of ordinary care and skill of the defendants, and of each of them.

The defendants deny these allegations; that is, they deny administering the chloroform contrary to the repeated objections of the deceased, M. L., and they deny that the chloroform was administered in such quantities as to cause death, or that it was administered in an improper and negligent or careless manner; so that you have, I might call them, two issues to determine: First, was the chloroform administered against the objection of M. L.; and, secondly, was it administered carelessly, negligently, or unskillfully?

Now, upon these points, the plaintiff has the burden of proof; that is, she must establish from the evidence in the case that the chloroform was administered by the defendants against the objections of M. L., or that if it was so administered, it was administered carelessly and negligently, and unskillfully, before she can recover in this action. If the evidence has left your minds in such a condition that you cannot answer these questions either one way or the other, then the plaintiff has not proved her case, and your verdict should be for the defendants.

You will observe that I have submitted the case to you in two aspects. The first is, did the defendants administer chloroform contrary to the objections of the deceased, M. L., and the second was in reference to the skill with which the chloroform was administered. You are to determine from the evidence whether or not M. L. objected to the administration of the chloroform. You have heard the testimony of the plaintiff upon that point. I charge you that an objection made by Mrs. L., or by the daughter, is

not an objection that the defendants in this action were bound to give heed to, especially when you consider that Mr. L. himself was present. Their wishes do not bind the defendants in this action. I do not pretend to repeat to you the exact words that were used by Mr. L., but you may remember it was something like this: Mr. L. said: "Don't give me chloroform, Doctor;" and then he said, subsequently, about the same time: "Don't hurt the old man, Doctor."

The statement of the witnesses for the plaintiff is denied by the defendants; that is, the defendants say that Mr. L. did not give a positive command not to administer chloroform, and, therefore, I leave this question of fact to you, to be determined from the evidence in the case. But if you come to the conclusion that the deceased did, in fact, say, "Don't give me chloroform, Doctor," I leave it for you to determine whether that was meant as a command, or whether it was the expression of a wish on his part that he was not to receive chloroform, the same as the other expression, "Don't hurt the old man, Doctor," or "Don't hurt an old man." That question of fact, which you will discuss among yourselves when you reach the jury-room, is to be determined by you from the evidence.

Now, if the doctors, against the wish of Mr. L., administered to him chloroform, they became trespassers on that moment, and they are responsible for the results of their trespass. I charge you that the evidence shows that Mr. L. died, not because chloroform was administered, or because ether was administered, but that he died because some kind of an anesthetic was administered to him; and you must find from the evidenee in the case that he died because chloroform was administered to him, for you can hold the defendants in this action upon the trespess view of the case, that I have presented to you.

There is another view that I have suggested to you, and that is the one relating to the skill and care and knowledge of the defendants. The law requires that physicians and surgeons shall be skillful in their profession, and that they shall exercise reasonable and ordinary care and diligence, care and dilligence proportionate to the importance of the case in hand. Physicians, however, do not insure success; they are only bound to have the ordinary amount of knowledge possessed by the average of the profession, and they are bound to use only that degree of care and skill that the nature of the case requires; that is, if it is an important case, if they are administering a deadly drug, they are bound to be more careful than they are when they administer a comparatively harmless drug.

Now, you are to determine whether the physicians have violated this rule that I have laid down to you; whether they have, in this case, failed to exercise care and skill. If they have not, then they are liable for the consequences of their act. If they have not, they are not so liable.

You have listened attentively and patiently, I have noticed, for the last two or three days to the discussions of the physicians upon this point. You have heard references made to the condition Mr. L. was in at the time the operation was performed. The doctors have told you of the examination that they made, and they have told you what they found and what they did not find; and then you have heard the other physicians testify as to whether or not their conduct under the circumstances was or was not careful.

It is unnecessary for me to go over all this testimony, because I know that it is comparatively fresh in your minds, and that it will be freshened up when you talk among yourselves. If the physicians used due care, they are not liable, no matter what the result of their action was.

You can easily see that, if a physician at all times was to be held liable for the bad results of an operation performed by him, we would have no operations performed, or any physicians to perform them. They would not take the responsibility; but they do hold themselves out as possessing special knowledge in their profession, and do also hold themselves out as exercising care and skill. If they do exercise care and skill, as I have said to you a number of times, they cannot be held liable. If they do not, they may be held liable. It is for you to say whether these physicians have violated the rule I have laid down to you.

The plaintiff sues to recover $5,000 as compensation for the death of her husband. She is entitled to recover such sum as will represent in your minds the pecuniary loss resulting to the next of kin of M. L. from his death, not to exceed

$5000. The statute allows you to fix the damage anywhere within the limit of $5,000, and you are to determine what sum, if you come to the conclusion to find for the plaintiff, will compensate the next of kin of M. L. for the pecuniary loss occasioned to them by his death. You have heard the testimony from his wife as to his earnings, and as to his general condition. You must remember, at this particular time, he was not the well M. L. of a few weeks before, but, on the contrary, was suffering from a gangrenous affection of the finger.

I think that Dr. Thomas, in referring to that, said: "You wouldn't let the man go and die, would you?" Therefore, you must take into consideration the condition that he was in at the time that they gave him the anesthetic.

The jury rendered a verdict in favor of the defendant.

## HOW TO RIDE A BICYCLE.

The proper position for a bicycle rider is, in the first place, an upright one. He should push nearly straight downwards with his legs—not backwards, as one must do who leans far forward. His arms should not be rigid and extended to their full lenth, but a little bent, and the handles can be easily adjusted to bring this about. The reason for the bent, or slightly bent, arm is evident after a moment's thought. If the arm is stiff, rigid, and extended to a full length, the "pull" which you give the handles on going up hill or, indeed, while running along a level road, is a dead pull. There is no life in it. Each jar to the machine is a jar to your body, your head and neck, and consequently a jar to your whole system. On the other hand, if you ride with the arms a little bent, and acting as a kind of buffer to all jarring influences, they will save you an injurious though unnoticeable shaking up each time you go out. The only way in which you will notice a change will be after you have become accustomed to the bent-arm method. Then you will find you can ride longer without becoming tired.

Another feature of this stiff arm is the position into which the shoulders are thrust. Try it; grow a little tired with a long ride, and then see where your shoulders are. You have gradually come to lean on your arms for rest. Both shoulders have been thrown far back; your head and neck are stretched far forward, and your chest has, so to speak, sagged forward out of its natural position. Keep this up long enough, and you will be a fine-looking specimen.

No, the weight of your body should never come on the hands and arms, but on your thighs, and thence be transferred to the seat, with the unconscious springy action of your legs, which in a measure allows some of your weight to come on the pedals. In this position your hands are free to guide your wheel; you body is erect; you do not then get into the habit of swaying from side to side to put more weight first on one side, and then on the other; and your whole muscular development is regular and normal. Try riding without putting either hand on the handles and sitting erect. If you ride well, you can easily keep you balance, and in an instant you will be in the correct position. Once in this position, place the hands lightly on the handle-bars, and you will be in a healthy, proper situation to gain benefit from your riding.

In riding ten miles, for example, I should never go the whole distance at one pace. Slow, steady riding has its merits, so has sprinting for short distances. When a good clear road looms up ahead, have a brush for two or three hundred yards with the boy who is with you. These little races are good things. They quicken your movements, and they keep you from forming bad habits, or letting your body sag into set, immovable positions. They also bring the muscles into a different kind of play.

In fact, in bicycle riding as in everything else, you should remember that there is a right and a wrong way; that you need not only endurance but speed, and that changing from one to another, keeping up variety, is one good way of avoiding bad habits.—*Harper's Young People.*

# SOCIETY REPORTS.

## PHILADELPHIA COUNTY MEDICAL SOCIETY.

*February 13, 1895.*

### ACETANILID VS. QUININE TO ABORT CHILLS AND FEVER; AND ACETANILID AS A DUSTING POWDER.

(See page 444.)

#### DISCUSSION.

DR. J. M. ANDERS: The paper which has just been read reports certain clinical facts of lively interest based upon personal observation. It seems strange at this time that anyone would assume to have obtained better results from the use of acetanilide in malarial intermittents than from the use of quinine. Unfortunately Dr. Brodnax does not offer any experimental facts upon which to base an opinion of the mode of action of the acetanilid. The well-known antiseptic action of the drug is the only explanation that I can offer. I believe that Dr Brodnax is a careful and reliable observer, and do not question the fact that cases of chills and fever were cured after even single doses of acetanilid. Although we have entered upon days of scientific therapeutics, I do not think that the days of rational empiricism have entirely passed away. We know that quinine cures chills and fever. Since that discovery nothing has been brought forward that will supplant quinine in the treatment of that disease. It is not impossible that such a remedy may be found; it may be that Dr. Brodnax has found it in acetanilid. I have met with cases of malarial intermittents in persons in whom there is an unpleasant idiosyncrasy against quinine. Now, in such cases, a better substitute for quinine than those we have at present would be welcome and of great advantage.

The question whether or not there are objections to the use of acetanilid might be asked. The statement has been made that acute dilatation of the heart sometimes occurs in intermittents. Now, it is known that acetanilid is a cardiac depressant, and in toxic doses has produced death by paralysis of the heart. While I do not consider this a bar to the use of acetanilid in the doses prescribed by Dr. Brodnax, I think that this influence makes it necessary to guard the heart during the time of its administration. If subsequent experience support these observations the profession and members of this Society should give a vote of thanks to Dr. Brodnax for a new remedy for malaria, and one which promises to rank as a specific.

DR. J. A. CANTRELL: My experience with acetanilid in the treatment of disease has been in two hundred cases, or more, of skin eruption, especially intertrigo and eczema. I believe it to be the antiseptic that we are looking for in the place of iodoform. It does not have any irritating qualities that iodoform has, and, in fact, a great many cases of iodoform irritation have been cured by it. In very moist cases of skin disease it acts as a drying powder and also as an astringent. In other cases, like zoster, it acts well, dries up the eruption, and apparently it acts as a stop to the disease; at least, it seemed at the time as if acetanilid had produced this action.

DR. G. G. DAVIS: Nobody would be more glad than myself for a satisfactory substitute for the foul-smelling iodoform. Combinations have been brought forward of boric acid and other substances with iodoform. The mixture of boric acid I prefer to the pure iodoform. The boric acid breaks up the lumps which the iodoform contains and makes it a more manageable substance as a dusting powder. I have also used acetanilid by itself, but have been unable to persuade myself that it is the equal of iodoform for surgical purposes.

DR. EDWARD MARTIN: I have used acetanilid in about a thousand cases of suppurating wounds, and my experience is, in these cases, that it is superior to iodoform. It is less toxic, for one thing. It is very common among surgeons to ob-

serve in slowly healing wounds dressed daily with iodoform certain nervous symptoms, headache, and so on, indicating iodoform poisoning. This is not seen in cases dressed with acetanilid; the wounds keep perfectly dry, there is no pus, and, of course, no odor, and the dressings keep as clean as with iodoform. I shall continue to use it in place of iodoform.

DR. DAVIS: I think that the direction of surgical progress as regards the application of powdered antiseptic substance in recent wounds is on the decline, and I have no doubt that both the iodoform and the acetanilid will be eventually much less used than at present. Dr. Halsted, of Baltimore, makes an application of silver leaf take its place. Of course, drying powders will always be used in the treatment of suppurating wounds.

---

Dr. Makuen presented

AN INTERESTING CASE OF RAPID SPEECH DEVELOPMENT IN ADULT, FOLLOWING OPERATION FOR TONGUE-TIE.

(See page 445).

DISCUSSION.

DR. THORINGTON: I would like the patient to say anthropological and ethnological. (The patient repeated them distinctly.)

DR. G. G. DAVIS: This is an extremely interesting case, and an instructive one. As regards the relative parts which the operative procedure and the painstaking instruction have played in bringing about the result, it would be extremely difficult to decide which of them contributed the most. The part that the tongue plays in speech is uncertain, and I doubt if it is ever very important. Of course, in a person who has talked, and then has been deprived of his tongue or part of his tongue, speech is still intelligible; but whether an individual that had the tongue removed in infancy, would learn to talk is indeed a question. In this case there might have been some anatomical condition that would cause limitation of movement of the organ, or acted as an obstruction to prevent his learning to speak, until later in life, he was able to undergo the systematic instruction which Dr. Makuen ordered for him, which might in itself be instrumental in producing speech. I regret that these means for overcoming defects of speech are not better known than they are among physicians. The simple division of a tendon may be followed by elongation; but in the case of the tongue the resulting scar-tissue might restrict its movement still further. In this case there is a practical demonstration that the tongue is more movable. The report of this case is an encouragement to others to repeat this method in similar cases. I do not think that it is extremely rare to find cases where no device is able to afford relief; this is so where there is difficulty in pronouncing those sounds which are produced by the tongue held in contact with the roof of the mouth, it being sometimes impossible to place the tongue there.

DR. MAKUEN: The remarks of the last speaker are very pertinent to the question. I am sure I cannot say which was the greater factor in the development of speech in this case—the instruction or the operation. Certain I am, however, that the one would have been of little value without the other, for during the three months immediately preceding the operation I gave him very careful drill, which resulted in improvement on certain words, but in no improvement whatever on all those sounds which require a free action of the tip of the tongue. It was only after the operation that he could give these sounds at all. The shortening which usually follows cicatrization was prevented by free exercise of the tongue and by frequent traction. He can protrude his tongue three-quarters of an inch further than before the operation, and as you see he has acquired great faculty in articulation.

---

Dr. Spivak reports a case of

VARICELLA COMPLICATED WITH GANGRENE OF THE SCROTUM.

(See page 447).

DISCUSSION.

DR. J. ABBOTT CANTRELL: I regret that Dr. Spivak did not give more of the history of his case. When Hutchinson (J.), ("On Gangrenous Eruptions in Connection with Chickenpox and Vaccination," *Proc. Royal Med. and Chir. Soc. Lond.*, 1882, vol. ix., No. 3, pp. 88-91) gave the name varicella gangrenosa to this affection he stated positively that it did

not occur with any other disease than varicella, but since that time he has somewhat changed that opinion. Besides being witnessed in connection with varicella it has been seen with miliaria rubra and lichen planus by Crocker (*Trans. Med. and Chir. Soc.*, December, 1888), with purpura by Moore (*Austrian Med. Journ.*, 1889), Büchler's case (*Amer. Journ. Med. Sci.*, Phila., 1889, vol. xcviii., pp. 265-268) occurring under bad hygienic influences. In addition to this it has been witnessed as an independent eruption, such as the cases recorded by Crocker (*loc. cit.*), Payne (*Trans. Path. Soc. Lond.*, 1884 85, vol. xxxvi., pp. 471-475), Abercrombie (*Trans. Path. Soc. Lond.*, 1879-80, vol. xxxi., p. 383), Bowley (*Lancet*, London, May 30, 1885, p. 98), Elliot (Morrow's *System of Genito-Urinary, Syphilogy and Dermatology*, vol. iii.,1894), and others will testify.

Witley Stokes (Crocker, *loc. cit.*) recorded it, in 1809, as a pemphigus gangrenosus; Bazin (Elliot, *loc. cit.*) also thought it to be a pemphigus; and Carpenter (*Illus. Med. News*, London, 1888-89, vol. i., p. 173) refers to a case under the title of pemphigoid varicella. Simon recorded an example under the name of multiple cachectic gangrene (Elliot, *loc. cit.*).

Its usual seat is at or near the buttocks, the inner and posterior portion of the thighs, although it may be witnessed on any portion of the body; thus, Büchler (*loc. cit.*) saw it affecting the mastoid process, the ear becoming involved in the destructive process later. Jameison (*Trans. Med.-Chir. Soc. Edin.*, 1886-87, 1888, vol. vi., pp. 19-21) witnessed a case affecting the head, face, back, and upon the right thigh.

It begins as an erythematous spot, scarlatiniform in character, and this was seen in Stanifooth's case (*Med. Press and Circular*, 1890, N. S., vol. xlix., p. 37) to precede any other change for twelve hours. This is followed by a papule, visicle, vesico-pustule or a pustule. These, one and all, rapidly change into a pustule, and after it reaches the size of a split pea, or even before it becomes that size, it ruptures, and we have the formation of a crust. The lesion at this time is surrounded by a reddish or pinkish-red, or even a livid zone. In a short time the crust begins to separate, and after its completion the process generally terminates, but this is not always so. When the crust has been removed we see an ichorous, ashen-gray mass or a purulent secretion at the bottom of the ulcer, which has a ragged floor, the ulcer looking to be a punched-out sore—in fact, resembling the condition we have when a vaccination pustule is at its height. When the disease begins, or is in connection with a vaccination, it is witnessed first on the same arm, but not at the point of vaccination. Constitutional taint seems to have an influence upon the aggravation of the disease, but this is denied by Hutchinson. Thus, in Payne's case the child died of acute miliary tuberculosis; Abercrombie's showed double pneumonia, with recent pleuritis of one side; Howard's (*Brit. Med. Journ.*, 1883, vol. i., p. 904) case showed dulness on percussion, the little patient dying of pyæmia, and the autopsy revealed abscesses in one lung, while two ounces of pus was taken out of the pleural cavity; Bowley's case died of convulsions the day after discharge.

The disease is supposed to be due to a parasite, although a constant germ has not as yet been demonstrated. Ehlers found the bacillus pyocyaneus in two cases, Kallinger found the staphylococcus cereus albus in one, and still others have been found.

The prognosis is favorable without the intervention of some complication such as lung troubles, as mentioned, syphilis having a deleterious effect.

Treatment must be upon the strictest hygienic basis, the patient is to be supported and given tonics, as well as the best of food; locally, antiseptics are to be freely employed.

DR. SPIVAK: I have simply reported my own case, and I did not intend to review the extensive literature of the cases which I have collected; neither did I wish to discuss the mooted questions in pathology. I reported my case on account of three interesting points: (1) There was only one lesion in my case, while all the cases reported hitherto were multiple; (2) the size was unusually large—about a silver dollar in circumference—as can be easily judged from the photograph; and (3) there is only one case reported where the genitala was mentioned to have been affected, and no distinct reference to scrotum made.

# PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M.D.

## MEDICINE

### Typhoid Fever.

Acting on the experiments of Werner, at St. Petersburg, showing that one-half per cent. of chloroform will kill the bacillus of enteric fever, and of McIntire, that carbolic acid not only controls the development of the bacillus but acts as an antiseptic on the intestinal canal, Dr. R H. Quill, of the British Army Medical Staff, in India, where the fever is most fatal, has treated all his typhoid cases the past year with the combined remedy, without the loss of a single case. The treatment was commenced by three grains of calomel, to clear the bowels of their contents, and followed by a mixture composed of thirty-six minims of carbolic acid, two drachms of the spirits of chloroform, three drachms of the compound spirits of cardamon, two ounces of syrup of nemidesmus, and added chloroform water to make twelve ounces. Of this mixture two table-spoons were given the first day every two hours; the next day five doses of the mixture were given, in iced water, and ten doses each day after, until there was a fall of temperature and marked general improvement, when it could be gradually decreased to three doses during the twenty-four hours, which should be kept up, to prevent relapse, for a week after the temperature was normal. Digestion continued in good condition, tendency to diarrhœa was checked, there was an absence of tympanites, and there was at no time any tendency to delirium or stupor, and convalescence was rapid.—*N. Y. Medical Times.*

### Dyspepsia Treatment.

Dr. J. B. Marvin has narrowed down the treatment of dyspepsia to very simple remedies. He finds that the mercurials yield the best results. Cases of biliousness are benefitted by either small doses of calomel, or calomel and ipecac, or the blue-pill. They relieve constipation and stimulate glandular secretion. Where these substances are contra indicated, he prefers salines in hot water, to wash out the stomach and empty the bowels.

Rest is next in importance. Though a certain amount of exercise be advisable, rest, together with long sleep, will be more necessary in nervous and hysterical persons.

Two patients with emesis were successfully treated by very small doses of potassium bichromate—one-tenth or one-twelfth grain (say one-half ctg.) in solution and on an empty stomach, two or three times daily.

In cases of deficient secretion, he administers hydrochloric acid in large doses (Ewald's method). Where there is hyperesthesia or some other neurotic symptom, he uniformly uses ammonium bromide (five to ten grains [thirty to sixty ctg.]) with half a fluid drachm (two c.c.) each of camphor-water and glycerin, adding sometimes one to two drops of Fowler's solution.—*Ex.*

### Tic Douloureux.

Dr. Jarre presented a report on the causation and treatment of tic douloureux of the face. His conclusions are as follows (*La Tribune Medicale*):

1. The disease known as spasmodic neuralgia, epileptiform neuralgia, tic douloureux of the face, etc., is due to a peripheral lesion seated in the terminal extremities of the fifth pair.

2. The exact and invaribie seat of this lesion is a more or less extensive portion of the alveolar border of the upper or lower jaw, which is the seat of a cicatrix consecutive to former accidents of different kinds.

3. The intracicatricial location of the original lesion brings tic douloureux into the same category as the neuralgia of the toothless, and the neuralgia affecting the stumps of amputated limbs, both of which are also of cicatricial origin.

4. The rational treatment of tic, therefore, ought to consist purely and simply of the ablation of that portion of the alveolar border comprising the original seat of the disease.

5. The ablation is done by first incasing the soft parts with the galvano-cautery knife, removing the alveolar border by the bone forceps or saw, and subsequently rasping the wound in the bone.

6. The operation is not at all grave; the wound dressed antiseptically heals, ordinarily, in a few weeks without complications.

7. The results so far obtained give reason to hope that we are now in possession of a simple, rapid and harmless means of curing tic douloureux, a disease which, up to the present, has been classed with incurable diseases.—*Dominion Medical Monthly.*

### Subcutaneous Inejction of Carbolic Acid in Rheumatic Affections.

Dr. Andre Martin (*Bulletin Generale de Therapeutique*) calls attention to the value of carbolic acid used by hypodermic injections as a means of relieving the pain of rheumatism and other painful affections. He was led to employ carbolic acid for this purpose by the observation of surgeons in the use of the method of Lister, that even very feeble solutions of carbolic acid possessed a considerable analgestic power when applied to wounds. Baccelli, in 1890, cured a case of traumatic tetanus by the hypodermic injection of carbolic acid, the curative properties of which were attributed by him to the

sedative effect of the drug upon the excitability of the cord. Backzy treated headache by carbolic acid fomentations. Kunze and Gillepsie treated articular rheumatism by hypodermic injections of carbolic acid. Gillepsie injected two fifths of a drop of a ten-per-cent solution into inflamed synovial sacs or just outside of the inflamed membrane. He attributed his success both to the anesthetic properties of the drug and to a specific effect upon the ptomaines secreted by the microbes of rheumatism.

Benedick, in 1892, cured many cases of functional spasm accompanied by localized pain by means of local injections of solutions of carbolic acid. M. Cheron, with others, have introduced phenic acid into the formulæ of their artificial serums. M. Martin, encouraged by the results obtained by others, has within the last two years employed injections of carbolic acid in one hundred cases met in military practice, comprising the following: Muscular rheumatism, articular rheumatism, peripheral neuralgias, wounds, pleurisy, intestinal colic, and other injections accompanied by pain. The results reported from this treatment are sufficiently satisfactory to warrant further trial, especially in cases of acute localized rheumatic affections.

### The Antiseptic Properties of Formalin.

The employment of Formalin as an antiseptic for the disinfection of rooms and buildings has again and again been advocated on account of the volatile nature of the formic aldehyde vapors. Some idea of the penetrating qualities of these vapors will be afforded by the results of experiments laid before the Paris Academy of Sciences last week by M. Trillat.

These experiments had been conducted on a most extensive scale, the apparatus being tested in rooms varying in size from 20 to 300 cubic metres, the walls having been covered with germs of very resisting nature at different heights. Various infected articles were also placed in the apartments. The results led to the conclusion being formed that the vapors took effect equally well both as regards height and depth, that is to say, that in consequence of the great diffusive powers of the gas it travels equally in all directions. The force of penetration of these vapors appears to be so great that, although they were used very diluted with air, drapery infected with germs and entirely purified—the various septic organisms with which it was inoculated being destroyed. Even wood was penetrated to a considerable depth, and the chairman, M. Friedel, drew attention to the fact that such results could not be obtained by the vapors of any other substance.—*New Eng. Med. Monthly.*

### A Fatal Case of Uncomplicated Chicken-Pox.

The *Australian Medical Journal* publishes an article by W. B. Nisbet, M.B., Ch.M., Ed., of Townsville, Queensland, in which he remarks that it appears to be a generally accepted fact that varicella is such a trivial disease that no treatment is required, and, as complications are extremely rare, no precautions are necessary to prevent their occurring. West writes, says the author, "The disease is one so void of danger that it hardly requires any treatment;" while Collie, in Quain's *Dictionary of Medicine*, says, "No physician has recorded a fatal case of chicken-pox." For this reason, says Mr. Nisbet, the following case is recorded, which might otherwise seem too trivial to be worthy of note: A healthy baby girl of eight months showed signs of the eruption of the chicken-pox on September 30, 1894. Four older children in the house also had it, and an epidemic of the disease was running through the town at the time, so the diagnosis was a matter of no difficulty. For the first three days the case progressed in the ordinary way, the rash being by no means copious and the constitutional disturbance unimportant. But on the fourth day a new crop of vesicles made their appearance, and were so numerous that by the sixth day every part of the child's body was covered, even the soles of the feet and the palms of the hands. The eruption showed no tendency to become confluent, except over the back, which was constantly rubbed by the restless movements of the child. On the seventh day numerous spots appeared on the tongue, on the hard and soft palate, and on the inside of the cheeks; these changed to irritable ulcers on the ninth day, causing great distress, and on the morning of the tenth day the child died, without any other complication making its appearance. The temperature remained at or about 102° F. during the illness, only once, on the evening of the fifth day, reaching 103°. It fell to 98.8° on the ninth day and remained normal up to the time of death.

Mr. Nisbet thinks that death was owing to the immense area of skin involved, in the same way as a very extensive burn causes death from shock in a child. The exhaustion evidently was so great that at the crisis of the disease, when the temperature fell to normal, no amount of artificial stimulation could avert the fatal issue.

### Singultus.

In a paper published in the *Physician and Surgeon*, Dr. D. L. Parker reports four cases of persistent singultus and the treatment employed. In each of the cases all the usual and known remedies had been tried without avail. In each case also, although the hiccoughing had gone on to the point of exhaustion of the patient, relief was at once obtained by dry cupping the abdomen, in two cases by ordinary drinking glasses, in the others by a cupping outfit. The author thinks, though we cannot see it as he does, that "the *modus operandi* of this remedy seems to be that by drawing forward a portion of the abdominal wall and thereby tending to enlarge the abdominal cavity, enough force is exerted upon the upper side of the diaphram, by atmospheric pressure to overcome its spasmodic action."—*N. Y. Medical Journal.*

### The Danger of Apoplexy During Narcosis in Elderly Persons.

Senger (*Deut. Med. Woch.*) calls attention to this danger during the narcosis of elderly people, especially in those cases where there is marked arterial sclerosis. He believes this accident has occurred in many cases where the diagnosis has not been made. He finds no such cases reported in anesthetic statistics or in the literature at his command. The case reported is as follows: A patient, fifty-six years of age, suffered from sarcoma of the breast, and healthy kidneys and heart, and her pulse was normal; the arteries, however, showed sclerosis. During the anesthesia there was no marked excitation, although there was some vomiting. Suddenly, while the face had been red, it became deadly pale and cold, the eyes fixed and expressionless, the pupils dilated and reactionless; the pulse could not be felt. The respiration, at first marked, became shallow and gasping, and then ceased altogether for a moment. Although the symptoms pointed to a centric and non-respiratory source of troubles, the author immediately began restorative measures, artificial respiration, external heat, and all the most approved means. After a short time the pulse and respiration again became normal, more chloform was given, and the operation completed. When the patient recovered from the ether she complained of stiffness in the right leg and arm, and difficulty in speaking, which proved to be a partial hemiplegia of the rignt side, which had occurred during the narcosis. Clonic spasm followed after a time in the lower extremity, but not so markedly in the upper, while the patient complained of cold in the foot. After six days the motion returned in part to the arm, but there was a relapse; when the patient left the hospital there was still considerable lameness, the leg having been slower in recovering. Two years later the paralysis had mostly disappeared, the foot dragging only slightly. Theiauthor believes this danger is greater with ether than with chloroform, as the arterial pressure is sustained longer in the former, and that consequently in elderly people with sclerotic arteries chloroform should be the anesthetic of preference.—*Amer. Jour. Med. Sciences.*

---

### An Antidote to Hydrocyanic Acid.

The *Lyon Medicale*, says that M. Johann Antal, a Hungarian chemist, has discovered a new mineral compound, nitrate of cobalt, which promises to be a very efficacious antidote in cases of poisoning with potassium cyanite or hydrocyadic acid. Tried first on animals, this product has since been employed, always successfully, in more than forty cases of accidental poisoning.—*New York Medical Journal.*

---

### Typhoid Fever in Infants.

The profession is gradually beginning to appreciate the fact that typhoid fever is more common in infants than was formerly believed. Various writers have contributed evidence to support this statement and Dr. I. N. Love concludes an article on this subject in the *Journal of the American Medical Association* as follows:

1. Typhoid fever occurs frequently in children than is generally supposed.

2. The fact that ulceration and hemorrhage is much less frequent would explain the absence of pronounced abdominal symptoms.

3. The erratic, undeveloped and hypersensitive nerve centers in early child life explain why the toxic secretions of the Eberth bacillus should make cerebral symptoms very pronounced.

4. Given a child of any age with or without intestinal disturbance, with a continued elevated temperature, with or without marked evidence of cerebral disturbance, the possibility of the presence of the Eberth bacillus of typhoid fever should be constantly kept in mind.

---

### A Case of Peripheral Paralysis Following Varicella.

The case is reported by William Guy (*British Medical Journal*). The attack of varicella was mild, but about a fortnight after he was found in the morning to be completely paralyzed in his lower extremities. No paralysis in other parts. For three weeks there was no improvement. Shortly after this he made attempts at walking, but recovery was slow. At the end of three months he could walk fairly well. In addition to the complete muscular paralysis, there was considarable sensory loss. All the muscles of the lower limbs were involved, but the extensors were more profoundly affected. Knee-jerks and plantar reflexes were absent. Abdomidal reflexes were active. The child, which was two and a half years old, was slightly rachitic, but there was no sign of syphilis.

---

### Infantile Scurvy.

In connection with a paper on infantile scurvy, Dr. Fruitnight reports the following case (*Archives of Pediatrics*) A boy, nine years of age, had, for a long time, subsisted on a diet made up chiefly of salted meats, dry rye bread, and black coffee. When seen by the author he had complained greatly of pains near the knee joints, which his mother termed "growing pains." There were oval swellings about both knee joints; they were very sensitive to pressure, and the boy made no attempt to walk, retaining the same position constantly on his chair, except when he would lie down. His gums were spongy, sore, and swollen, and bled very easily. He showed many minute ecchymotic points. His teeth were loosened and covered with tartar. Breath very foul. He had alternate constipation and diarrhœa, and was very anæmic. He was put upon anti-scarbutic diet, potatoes, fresh vegetables, fruits, lemonade, beef and mutton, with citrate of iron and quinine, with dilute muriatic acid three times a day. Within ten or twelve days he was practically well.

### Smallpox Ameba.

Dr. Maximilian Herzog, of Chicago, claims to have discovered a "smallpox ameba," the presence which in the blood on the first or second day after vaccination is the only sure test of a successful vaccination. No matter how swollen the arm or uncomfortable the patient, the vaccination is not effective unless the "ameba" is found, the unpleasant symptoms being due to the vaccine points being loaded with croton oil, or some other irritant—*Boston Medical and Surgical Journal.*

### Digestibility of Sterilized Milk.

Bendix (*Jahrbuch fur Kinderheilkunde*), has made researches upon sound and sick children as to the digestibility of both sterilized and nonsterilized milk. He concludes:

1. That in healthy children there is no difference as to the digestibility of the two milks.

2. In sick children the sterilized is digested just as well as the unsterilized, notwithstanding the fact that the absorption of fat and nitrogen is so much reduced in such children.

3. The taste and smell of milk, while they may be changed by sterilization, are not materially so, and sterilized milk is readily taken by children.

4. He has never seen the health of children badly affected by the use of sterilized milk. On the other hand, they eat well, grow, and their stools are normal, and they never have vomiting.

5. The transmission of severe diseases from animals to men is prevented by the sterilization of milk.

6. Sterilization is much preferable to Pasteurization, and heating the milk to 212° F., while it does not hinder its digestion, absolutely kills all bacteria and spores.

### On the Value of Quinine as a Remedy in Cholera.

In this paper, which appears under the title of Is there a Better Remedy in Cholera? the writer strongly advocates the use of quinine, given either in powder or in solution by the mouth, as a remedy in this disease. Reviewing the list of remedies which kill the germs, he says that it is manifestly impracticable to kill the sprilla outright in the intestinal tract of a human being whom we expect to live, hence he looks for the least harmful inhibitant, which he considers undoubtedly to be quinine. Twenty or forty grains of quinine, given by the mouth, is sufficient to inhibit the development of the microbe in any quantity of the rice-water exudate presumably present in the alimentary canal. Absorption takes place to a very small degree on account of rapid peristalsis. Therefore symptoms of cinchonism are not noticed, even after repeated doses. He quotes statistics to show that in those cases where it was given in full doses by the mouth it has lowered the mortality in severe cases to twenty-five per cent., and only in those cases where it is has been given hypodermically did it prove ineffectual. At the same time other means of treatment should be made use of, as may be found necessary; the application of heat to the body, saline subcutaneous injections, and morphine, and small doses of calomel for the diarrhœa.—E. B. Fullerton, M. D., in *New York Medical Journal.*

### Ipecacuanha in Alcoholism.

Dr. W. F. Waugh, writing to the *Medical World* says: In treating a man for alcholism I wanted to put something in his whiskey to sicken him, and so gave a little fluid extract of ipecacuanha—about 20 minims. It did not nauseate him, but he went to sleep and slept all night. This seemed curious, as he had previously taken 40 grain doses of chloral and of sulfonal, without inducing sleep. Next day I gave him the same dose, without the whiskey and he slept all day. Following this, for a week, I put him to sleep every night on the ipecacuanha, and he had the best week's sleep he had had for years. I gave him the fluid extract, 10 to 30 minims, in a spoon with no water, and directed him to lie perfectly quiet for five minutes after taking the medicine, in order to avoid nausea and vomiting. This is the way to give ipecacuanha for the grave forms of dysentery. Now if this drug will give sleep in such cases it is of importance, for we know that very often they resist such drugs as opium, chloral and bromides, until such hugh doses have been taken that life is endangered thereby.

### Indications for Iron.

Iron is indicated in all anæmias unless they are accompanied by fever or due to some malignant disease. In chlorosis the carbonate, made extemporaneously by combining the sulphate of iron with the carbonate of potassium, should be used.

After fevers there is always more or less anæmia.

The weakness of the muscular system is shown by the acceleration of the pulse, due to cardiac weakness on the slightest exertion, as setting the patient up in bed, Iron combined with restoratives should always be given.

In Bright's disease, the muriate tincture, combined with corrosive sublimate and sweet spirits of nitre, can be given.

In diabetes, iron should be given; constipation should be carefully guarded against. The iron should be given with a laxative.

Nervous exhaustion, accompanied by the accumulation of phosphates and hæmatin in the urine, calls for iron.

In chronic constipation of women; uterine disease, characterized by weakness of the uterus or its supports prolapsus uteri, etc.

### Early Signs of Pregnancy.

It has been taught that the diagnosis of pregnancy in the first three months is very

difficult or even impossible. This Dr. Charles P. Noble contradicts in the *Philadelphia Polyclinic*. In his experience, careful abdominal palpation will make it out as early as the sixth week or at any time between the sixth and twelfth weeks. The sign, he says, has never failed him in his dispensary work, but almost all of these cases came in to see if pregnancy existed, and as they were illegitimately pregnant it was possibly rather an easy guess. The shape of a virgin uterus is pyriform, while a uterus in which there is an ovum but a few weeks old will have grown sufficiently to cause the body and fundus of the uterus to assume a spherodal shape.

The conditions which he found to simulate pregnancy were hematometra, which is very rare and usually occurs at the time of puberty; and intramural fibroid tumors, which on account of the asymmetrical shape given to the uterus, may be left out of the question. When pregnancy occurs in a uterus where there is already a fibroid or if the uterus be jammed between tumors of the ovary then the diagnosis is very difficult, and when the patient is very stout palpation is not easy. Still, in general, he thinks a pregnancy can be told with certainty in the first twelve weeks and he emphatically makes this statement in view of his large experience.

---

### The Treatment of Warts.

The *Union Medicale* says that when one has to deal with isolated warts, they must be taken off with a scoop; a rather abundant hemorrhage follows, which may be arrested by compression or by cauterization. When warts exists in large numbers, this procedure is no longer applicable, particularly on account of the numerous cicatrices that follow its employment. In these cases the better way is to shrivel the excrescences with nitric acid. The tincture of thuja is also a very efficacious topical application.

In cases of condyloma the small tumors may be dusted with powdered resorcin or salicylic acid; they may also be covered with a plaster containing these substances in the proportion of from ten to twenty per cent. When the face is studded with a large number of these little warts, which often appear suddenly, Dr. Kaposi covers them with a piece of flannel spread with a layer of black soap. This is left on the warts for twenty-four hours and adheres to the skin, gradually becoming detached with the warts.

Another very good application is the following mixture: Flower of sulphur, 20 parts; glycerin, 50 parts; pure concentrated acetic acid, 10 parts. The warts are painted with this mixture for several days without taking off the first layer, and gradually the excrescences dry up and become detatched.

For keratosis of the palms of the hands and the soles of the feet plasters of resorcin and salicylic acid are also efficacious. If the case is one of molluscum like nævus it is better to employ electrolysis. The needle connected with the positive pole is plunged into the tumor, and a current is passed of from one to two milliamperes for about thirty seconds. This operation is repeated at the end of eight and fifteen days. When the nævus is very large, the galvano-cautery is preferable.—*New York Medical Journal.*

---

### Ætiology and Treatment of Cystitis.

The author, M. English, (*Le Semaine Medicale*), had already observed that cystitis is not always of microbic origin, but may be due to chemical irritants or to traumatism. He has recently observed four cases of a new variety described as epidemic cystitis. Two important symptoms among those that characterized the disease were retention of urine and profuse hemorrhage following the use of the catheter.

The influenza has a decided effect upon the urinary organs. Existing disorders are augmented, and in previously healthy subjects urinary symptoms are manifested during the influenza, notably hæmaturia.

Among the causes of cystitis are mentioned disease of the kidneys, ureters, prostate and urethra, chemical modifications of the urine (oxaluria, etc.), and, lastly, affections of the central nervous system, such as tabes, and arteriosclerosis and certain chemical agents.

As to treatment, when of constitutional origin, the diathesis is first to be combated. The local treatment depends upon the condition of the mucus membrane of the bladder. Catarrhal cystitis is best without local treatment. Purulent cystitis always demands local treatment. Lavage of the bladder is very important in carcinomatous and tubercular cystitis. Solutions of boric acid are ordinarily to be used; the use of nitrate of silver frequently causes severe inflammation.

---

### Scarlatina and Measles Coexisting in the same Person.

On June 29th last I saw a boy of nine who had sickened and complained of sore throat that morning; next day a scarlatinal rash was undoubted. By July 6th desquamation was distinct on neck, breast, abdomen and thighs. On the 9th he had severe coryza and a constant irritating cough On the 10th I found him covered over with a most intense eruption to measles. Desquamation, as if accelerated by the second skin attack, proceeded with unusal rapadity. I was not able to trace the source of infection, but it is noteworthy that the two poisons must have found a lodgment in the child at much the same time. The boy made an excellent recovery.—*James Ferguson, M.B., C.M., in British Medical Journal.*

---

### Nutmeg Poisoning.

Nutmeg is seldom used in medicine except as a flavor, but as a household spice it has long been helpful in flatuency. Cases of poisoning from its use are not common and for this reason the one reported by Dr. Alexander L. Hodgdon, in the *American Medico-Surgical Bulletin*, is of interest. The patient ate four nutmegs within a few hours and went into a state of alarming collapse. By the use of heat and such cardiac stimulants as caffein, digitalis, nitroglycerine, etc., all evil effects were removed and the case recovered.

### Strontium Bromide in Gastritis.

An Italian physician says that strontium bromide is particularly valuable in gastric affections, especially acute catarrh, which, he says, shows anew the remarkable favorable action of the drug. Carseli uses a syrup by dissolving

| | |
|---|---|
| Strontium bromide..... | gr. xxx. |
| Syr. bitter orange peel..... | fl. ʒj. |
| Distilled lettuce water ..... | fl. ʒiijss. |

This amount is to be taken daily in three doses, during and after meals. It stops the vomiting and lessens pain. It is thought to act both directly upon the nervous system and as an antiseptic, arresting fermentation and thereby reduciug the flatulent distention that gives rise to the pain.

## SURGERY.

### Caution to Anesthetizers.

During a recent clinic by Prof. Hunter McGuire in the new amphitheatre of the College of Physicians and Surgeons, Richmond, Va., while chloroform was being administered to a patient on whom excision of portions of the bones of the leg was about to be performed; the patient suddenly stopped breathing, the face became purple, while the heart continued to beat. In a moment Dr. McGuire recognized that the condition was due to the dropping back of the tongue, obstructing breathing. With thumbs behind the rami of the inferior maxilla, he pushed the bone forward, thus lifting up the tongue, and the patient at once began breathing easily, and was kept thoroughly under the anesthetic for the time necessary for the operation. While this procedure is not, by any means, a new one, it is worth while to record such incidents so as to keep the surgeon or physician well on his guard so as to act the moment when bystanders are dazed at the shock of an impending accidental death. In short, in using an anesthetic keep your wits about you and look out for the sudden emergencies. —*Virginia Medical Monthly.*

### The Danger of Anesthetizing Diabetics.

The danger of narcotizing diabetics is not as generally known as it should be. As many as twelve fatal cases have been recently recorded. Even in slight cases of diabetes, patients are apt to become comatose and die. Not immediately, but several hours after the chloroform narcosis has passed off. They become indifferent, stupid and confused. Finally lose consciousness, pass into coma and die.—*Charlotte Med. Jour.*

### Two Cases of Intraperitoneal Rupture of the Bladder.

Coats records (*British Medical Journal*) two fatal cases of rupture of the urinary bladder, and adds the post-mortem records. In studying these cases the following points seemed especially worthy of comment:

*The absence of a clinical diagnosis in both.* There was no clear history of violence in either case, and the symptoms were obscured by the fact that one patient was maniacal and the other deeply intoxicated.

*The seat and size of the rupture* were similar in the two cases. The tear was found in the posterior wall of the bladder, a short distance from the fundus, being circular in the first case and transverse in the second.

*The interval of time between the rupture and the death* of the patient was in the first instance five days, and two to three days in the last. Of 85 cases collected by Rivington, 8 died within twenty-four hours; 15, within two days; 15, within three days; 16, within four days; 10, within five days; 4, within six days; 5, within seven days; 5, within eight days; 1, within nine days, whilst 1 lived twelve days; 1, more than twelve days; 1, fourteen days; 2, about fifteen days; and 1, sixteen clear days.

*The absence of peritonitis* was a surprise to the author, who states that none of the ordinary evidences of acute peritonitis were present.

*Absence of inflammatory reaction in the wound* was noted, particularly in the first case, even in the microscopic examination of the edge of the wound and adjacent bladder wall. Ferraton, in 1883, recorded two cases that received external wounds simultaneously with rupture of the bladder; he observed that at the time of death the wounds presented exactly the same aspect as at the time of admission to the hospital—"they presented no trace of a process of inflammation and repair."

*The mode of death* is directly related, in the opinion of the author, to the absorption of the urine by the peritoneum, and its continuous accumulation in the blood, to which condition Coats applies the term "urinary poisoning."

## NEWS AND MISCELLANY.

### The Rules and Regulations that will Govern the Division of Pathology Bacteriology and Disinfection of the Board of Health of Philadelphia.

The Sanitary Committee of the Board of Health submitted to the latter body at its meeting to-day a series of rules and regulations that will govern the recently organized division of Pathology, Bacteriology and Disinfection, of which Dr. B. Meade Bolton was recently appointed the Chief Bacteriologist. The rules and regulations which were adopted are as follows:

There shall be organized a Division of Pathology, Bacteriology and Disinfection, to be called the "Division of Pathology, Bacteriology and Disinfection of the Board of Health." There shall also be organized and established, in connection with the abovenamed Division, a laboratory for bacterio-

logical investigation and experimental research on questions pertaining to public health and hygiene. The Division of Pathology, Bacteriology, etc., shall be in charge of a chief, who shall be a physician, and an expert in bacteriology and well versed in pathology and the methods of investigation. He shall be called the "Chief of the Division of Pathology, Bacteriology and Disinfection" and "Director of the Laboratory of Hygiene" of the Board of Health.

He shall have an office in City Hall in connection with the office of the Board of Health. The laboratory shall be located in City Hall, where the best facilities for conducting the entire experimental work of the Division shall be provided.

The chief shall be held responsible to the Board of Health for the reliability of the work of his assistants and the proper use and custody of the property connected with the Division, and for the active, progressive and efficient work of the office.

He shall, so soon as appointed, prepare a plan for the establishment of the laboratory, and furnish an outline of the work to be undertaken, and draft rules and regulations for the government of this work, to be submitted for the approval of the Board of Health.

The scope of the work imposed under this new division shall be extended, so far as practicable, to all questions which affect the public health, relating both to preventive and curative medicine; the latter, so far as it includes the preparation of means for the prevention and curtailment of diseases by such processes as vaccination, the preparation and directions for the use of such material as the anti-toxin of diphtheria and sterilized serum of rabies, etc., etc.

There shall be two assistant bacteriologists, one clerk (who shall be a stenographer), one helper, one messenger, and three collectors of culture tubes.

So soon as practicable after the establishment of the laboratory, steps shall be taken to prepare, in ample quantity for the use of the city, the anti-toxin of diphtheria after Behring's or Roux's method.

Steps shall also be taken at once for the prompt examination of all specimens of exudate from throats of "suspected" cases of diphtheria and report thereon, the proper announcement being made to physicians of the facilities afforded by making prompt and reliable tests and the means of taking advantage of them.

The Chief of the Division of Pathology, Bacteriology, etc., shall report regularly to the Board of Health upon the work of his division, and as the work more particularly concerns measures for the management and suppressions of contagious and infectious diseases, he shall be in close communication with the Sanitary Committee of the Board of Health, and subject to their direction and control.

The laboratory shall be provided with a telephone to facilitate communication.

The Chief shall keep himself in constant communication with the medical inspector so as to place at his disposal all information that will be of practical aid in the successful management of the Division of Contagious and Infectious Diseases, especially such information as has a bearing upon the duration of the period of isolation and of quarantine, and the time for disinfection as determined by bacteriological examination.

The chief shall prepare, for the purpose of making bacteriological diagnosis in suspected cases of diphtheria, the necessary culture outfits and printed for distribution to stations at convenient points throughout the city. A list of these stations shall be published, at which physicians can obtain the outfits free of cost. The culture-tubes shall be collected once a day, or oftener if deemed advisable by the chief. When cultures are not made by the attending physician, they should be made by the assistant medical inspector, when no objection is raised by the attending physician. A report in all cases should be made as soon as practicable to the attending physician of the results of the bacteriological test, either by mail or telephone.

Diagnostic tests shall also be made for physicians who desire it in all cases of suspected tuberculosis whenever specimens of the expectoration are left at the station or sent direct to the laboratory.

The chief shall prepare printed forms to be filled out by physicians, and to be filled out in reporting to physicians the results of the cultures, and such other forms as may be used in the office.

The chief shall make requisition upon printed form to the Sanitary Committee for all the supplies needed. He shall mark as correct all bills that meet his approval.

The chief of the Division of Pathology, Bacteriology, etc., shall advise from time to time the best means of increasing the efficiency of the work of the disinfecting corps, and shall arrange for a practical course of instruction on "Disinfectants and Their Uses," to be given to the members of the corps.

The work of the Laboratory of Hygiene and of the Chemical Laboratory shall be cooperative in furthering the chief purpose of their organization.

The Laboratory shall be kept open from 9 A.M. to 6 P.M.; and, as the interruption of the work of making diagnostic tests may jeopardize life, provision shall be made for the continuous and uninterrupted prosecution of this special branch of investigation.

The Assistant Bacteriologist shall be under the special supervision of the Chief, and shall be responsible to him for the faithful and efficient performance of the duties assigned to them.

The object of the establishment of the Laboratomy of Hygiene is not merely the application of knowledge for the benefit of the community. The purpose of its establishment is also the utilization of accumulated data by drawing deductions therefrom, experimental research in the field of the etiology of disease, and the study and investigation of all subjects related to preventive and curative medicine so far as they appropriately come within the scope of such an institution.